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ABSTRACT

The report describes the delivery of services to the mentally retarded in the states of California, Colorado, North Carolina, Ohio, and Washington. Reported are such data as number of residents in state institutions and per 100,000 population, number of 24-hour care community placements, enrollees in special education programs and sheltered workshops, and costs of each. A program model is presented and used as a gauge of the effectiveness of state programs. No one state ranks consistently high or low in all categories of service. Rather, a high-low randomness is evident among the states and among departments and agencies in any one state. Following a discussion comparing the planning, coordination, and organization of services in the five states, each state program is examined. The following topics are covered as they relate to services for the mentally retarded: demographic data, local governments and districts, revenue and expenditures, state organization, planning and planning coordination, legislation, and the various types of services provided (residential institutions, community centers, day care sheltered workshops, rehabilitation, medical services, social services, special education, and others). (KW)

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Delivery of Services to Mentally Retarded Children and Adults in Five States

The President's Committee on Mental Retardation
Washington, D.C. 20201

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DELIVERY OF SERVICES
TO MENTALLY RETARDED CHILDREN & ADULTS
IN FIVE STATES

U.S. DEPARTMENT OF HEALTH, EDUCATION
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Prepared for the
President's Committee on Mental Retardation

(Contract No. HEW-OS-70-113)

by

Tadashi A. Mayeda
Ontario, California
January, 1971

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SECTION I - INTRODUCTION

A six-month study and analysis of stage systems for delivering services to mentally retarded children and adults in five states was conducted on behalf of the President's Committee on Mental Retardation during the early and latter months of 1970. The objective of the study was to understand the problems and interpret the needs of state agencies and departments in providing diversified and integrated services to the mentally retarded.

The study was conducted in California, Colorado, North Carolina, Ohio and Washington. These states were chosen because of their variations in size, population, population density per square mile of land, revenue, expenditure obligations, legislative mechanisms, state and local government relationships, and various other factors which describe the environment in which service programs for the mentally retarded are developed.

The study revealed that the five states have a high-low scattering of capabilities. No one state ranks consistently high in all categories of service nor does another rank consistently low. An up-and-down randomness appears among the states and sometimes among agencies and departments in any one state.

The capabilities to which the study was addressed included such numerically definable entities as the number of residents in state institutions, the number of residents per 100,000 population, the number of 24-hour care community placements, the number of such placements per 100,000 population, enrollees in special education classes, the census of sheltered workshops, and the costs associated with each.

Most of these data are available and the states can be ranked according to statistical accomplishments. However, statistics are not always meaningful and data have to be interpreted in the context of the concept of care being developed by the state. Two states, for example, hold to the premise that a series of small institutions dispersed throughout the states can provide a service in addition to that which can be provided by community facilities. One of these states plans to increase its overall institutional census; the other plans to reduce census slightly below current levels. The remaining three states hold to the view that institutionalization is a state facility is undesirable and that residence in a facility located within a community offers greater promise to the individual. In one case, therefore, the institutional census will rise. In the other four, the overall census will decline. Statistics should be interpreted accordingly.

The study also addressed capabilities not easily described in numerical terms. For example, the statistics of services being provided to the mentally retarded are hazy in the areas of welfare, rehabilitation, and pre-school programs. States cannot accurately count the numbers of mentally retarded persons receiving welfare services. Additionally, rehabilitation and pre-school services to the mentally retarded are only partially accurate. Statistics are valid only for those persons discharged from state mental retardation facilities who receive services from welfare placement groups, for those persons enrolled in sheltered workshops, and for those children in pre-school classes known to be developmentally deficient. Unless the individuals are clearly identified as being mentally retarded and mental retardation is a requirement for enrollment, no actual service counts can be made. Labeling for the sole purpose of determining eligibility is so patently undesirable that it is unlikely that complete statistics will ever be available.

The study relied to a certain extent on statistics. To a greater extent, it relied on a comparison of state activities with the program model described in the following section. The purpose of the comparison was to find out where state services were strong and where they were lacking or weak. The study revealed a number of promising state ventures on behalf of the mentally retarded. These are not listed as such in any single section but are interspersed throughout the report.

Despite the fact that all states have made commendable progress in providing services to the mentally retarded particularly during the past ten years, their ventures have been limited to only a part of the broad front of the problem.

In the period before the birth of a child, more has to be done with monitoring or intervening in high risk situations.

During the period between birth and school years, casefinding should be more vigorous and intervention programs should be mounted for all children considered to be at risk.

During the school years, a stronger tie should be developed between the school, the community facility and the parent. The parent should be recognized and developed as a strong resource.

For a problem as complex as mental retardation all nursery, pre-school, and special class teachers must be trained and certified to teach these children. Training should be offered to foster home parents and all other caretakers of mentally retarded children.

Youth and young adult programs must be strengthened because of the many transitional problems that appear at this time. Very often, youths are too old for school but not yet ready for anything else. Sheltering programs must be broadened. In all aspects, adult programs must be expanded.

Above all, the states must be encouraged to attack the problems of the inner city, rural areas, and the migrant populations. All states have reported difficulties in these areas despite efforts to the contrary.

On these and other crucial problems, the states need assistance.

SECTION II - PROGRAM MODEL

The Panel, commissioned by the President in the early 60's to look into the lack of attention of the nation to the problems and needs of the mentally retarded or those who were exposed to situations potentially leading to developmental deficit, provides a guideline for the study of delivery of service programs.

The Panel's report to the President entitled, "A Proposed Program for National Action to Combat Mental Retardation" laid out the fundamental strategy along a broad front for an attack against the problem. Almost ten years later, that strategy appears to sound and is used, in this report, as a gauge of the effectiveness of state programs.

The Panel's strategy covered the following subjects: (1) research in the causes of retardation and in methods of care, rehabilitation, and learning; (2) preventative health measures; (3) educational programs and enriched programs of special education; (4) comprehensive and improved clinical and social services; (5) improved methods and facilities for care with emphasis on the home and the development of a wide range of community facilities; (6) a new legal as well as social concept of the retarded; (7) manpower; and (8) education and information to increase public awareness.

Four of these subjects are directly related to service programs (prevention, education, clinical and social services, and methods and facilities for care). The remaining four (research, legal concepts, manpower, and public information) are classified as being indirectly related to service. This distinction is carried through the body of this report.

The Panel's recommendations on clinical and social service programs are modified by the use of three terms - comprehensiveness, community centered, and continuity. All three terms have, in turn, become cornerstones in the various state plans to combat the problem of mental retardation at the state and local level.

In the section of the Panel's report on clinical and social services there is a diagram showing the array of direct services required by the mentally retarded for any given stage in life. Life stages range from infancy to adult and the array of direct services range from early infant sensory stimulation to old age assistance. Included in the array of direct services are foster care, short stay homes, residential care, sheltered workshops and other special services required by the mentally retarded.

Figure 1 shows the general program objectives of the states in providing services to the mentally retarded. This figure, with a dimension showing the array of services required by a mentally retarded person during any given day, was used as the model for the study of the delivery of services in the five states.

The horizontal axis of the diagram is the life stage of the individual starting before birth and extending through adulthood. Dotted lines intersect this axis at birth, during the period between 5 and 6 years of age, and between 17 and 18 years of age because of the traditional significance of these ages in the child's relationship to society.

The vertical axis depicts the daily array of services usually needed by or provided to most individuals. This is the dimension which was added to the diagram originally contained in the report of the President's Panel. Although the daily cycle of need was implied by the use of the word "comprehensive" in the Panel report, there is reason to believe that these daily needs should be listed because community services do not always provide the complete array of daily services required by the mentally retarded individual. General services available in many communities are clustered above the horizontal axis. The special services required by the mentally retarded are clustered below the horizontal axis.

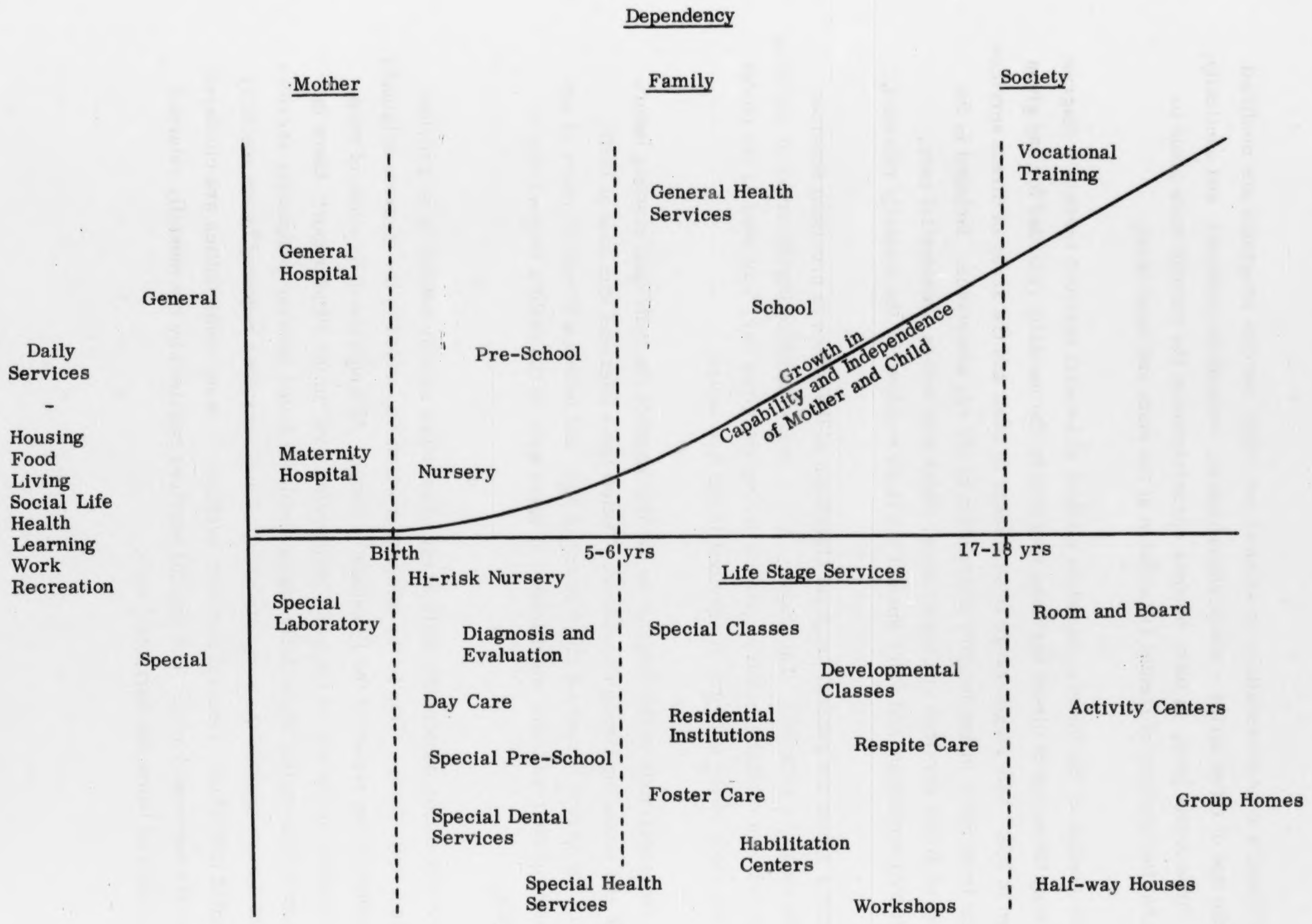

Dependency
Mother
Family
Society
Daily Services
-
Housing
Food
Living
Social Life
Health
Learning
Work
Recreation
General
Special
General Hospital
Maternity Hospital
Pre-School
Nursery
General Health Services
School
Vocational Training
Growth in Capability and Independence of Mother and Child
Birth
5-6 yrs
17-18 yrs
Life Stage Services
Special Laboratory
Hi-risk Nursery
Diagnosis and Evaluation
Day Care
Special Pre-School
Special Dental Services
Special Health Services
Special Classes
Residential Institutions
Foster Care
Habilitation Centers
Developmental Classes
Respite Care
Workshops
Room and Board
Activity Centers
Group Homes
Half-way Houses

Figure 1 - General Program Objectives

The line starting at the "zero" coordinates and rising to the right is one way of depicting the generalized objectives of programs for the mentally retarded. This line can be considered an approximation of the growth and development of a child or as the growth in capability and independence of the child. In effect, the objective of programs for the mentally retarded is to develop the capabilities of the individual to whatever potential, however limited, exist in the child and by this means to develop an independence in the child which might otherwise not be revealed. The rising line is essentially the ultimate goal of service programs. Not having attained this goal at any given point in the life stage of an individual or knowing that this goal might never be achieved fully are not significant. What is significant is the fact that a closer approximation of independence can be made, to the benefit of both the individual and society, with determined intervention.

The mother, as well as the child, is included in the "growth" line for the reason that capability and independence of the child has, in most cases, a direct bearing on the capability of the mother to nuture her child and her independence of the sometimes debilitating crutch of public and private services. This statement is made in the context of the Panel's report which describes the mother, whenever she has the capabilities and understanding, as a major resource because she possesses a motivation to provide care hard to duplicate in any out-of-home situation. It follows that no mother can be expected to carry the responsibilities of a retarded child without outside support. This support, to the degree that it is required by circumstance, life stage, and the particular needs of the mentally retarded person is the problem that confronts the various states.

The generalized program objectives are applied to state services with the addition of the terms comprehensiveness, community centered, and continuity. State services are patently deficient if any of these ingredients are missing or if the full array of services are not provided.

More often than not, most of these services are provided. It then becomes a matter of how well the services of the state work together on behalf of the retarded and if undetected barriers exist which limit services to certain individuals or areas of the state.

Another major factor in the delivery of services by states to the mentally retarded is the variety of services required at any one given life stage. The array includes a series of services only occasionally required by individuals but no less important than the continuous, long-term services so often demanded. Among the occasional services are diagnosis, evaluation, counseling, treatment, general health care, and general dental care. These are interspersed between the long-term needs of housing, food, training in living skills, training in social actions, communications training, general learning, vocational training, and recreation. Other than the fact that individuals suspected of being mentally retarded start the cycle of care with a diagnosis and evaluation, these services follow no set sequence. Organizational services are pressed to respond to such individual demands. This factor is considered also in this report.

SECTION III - PLANNING, COORDINATION, AND ORGANIZATION

All five states have adopted the concept of organizing services in such a manner that a central or fixed point is available for the guidance, assistance, and protection of retarded persons.

In the states of California and North Carolina, the nine Regional Centers of California and the twelve Developmental Evaluation Clinics of North Carolina serve this function. In the states of Colorado, Ohio, and Washington this responsibility is assigned to the various community centered programs.

Figure 2 illustrates the basic concept. In effect, as a child proceeds through various life stages there will be a fixed or central point of intake to which the child, in theory, can be referred at any time. This central organization, armed with knowledge of resources in the area, guarantees continuity of care if it is available at all. The central organization undertakes the tasks of diagnosis, evaluation, counseling, coordination of services; and, in some cases, providing services.

With the same concept in mind, arrangements for centralization differ from state to state. The nine Regional Centers in California, sponsored by retarded childrens' associations or non-profit hospitals, are under contract to the State Department of Public Health for service as well as diagnosis and counseling which may be provided by the sponsoring institution or purchased from various community sources. The occasional services of diagnosis and counseling, which by state law, may not be charged to the parent, are mixed with placement services. This situation differs from that of the Developmental Evaluation Clinics of North Carolina in the respect that the North Carolina DEC's handle short-term tasks only and are not involved in long-term placement services.

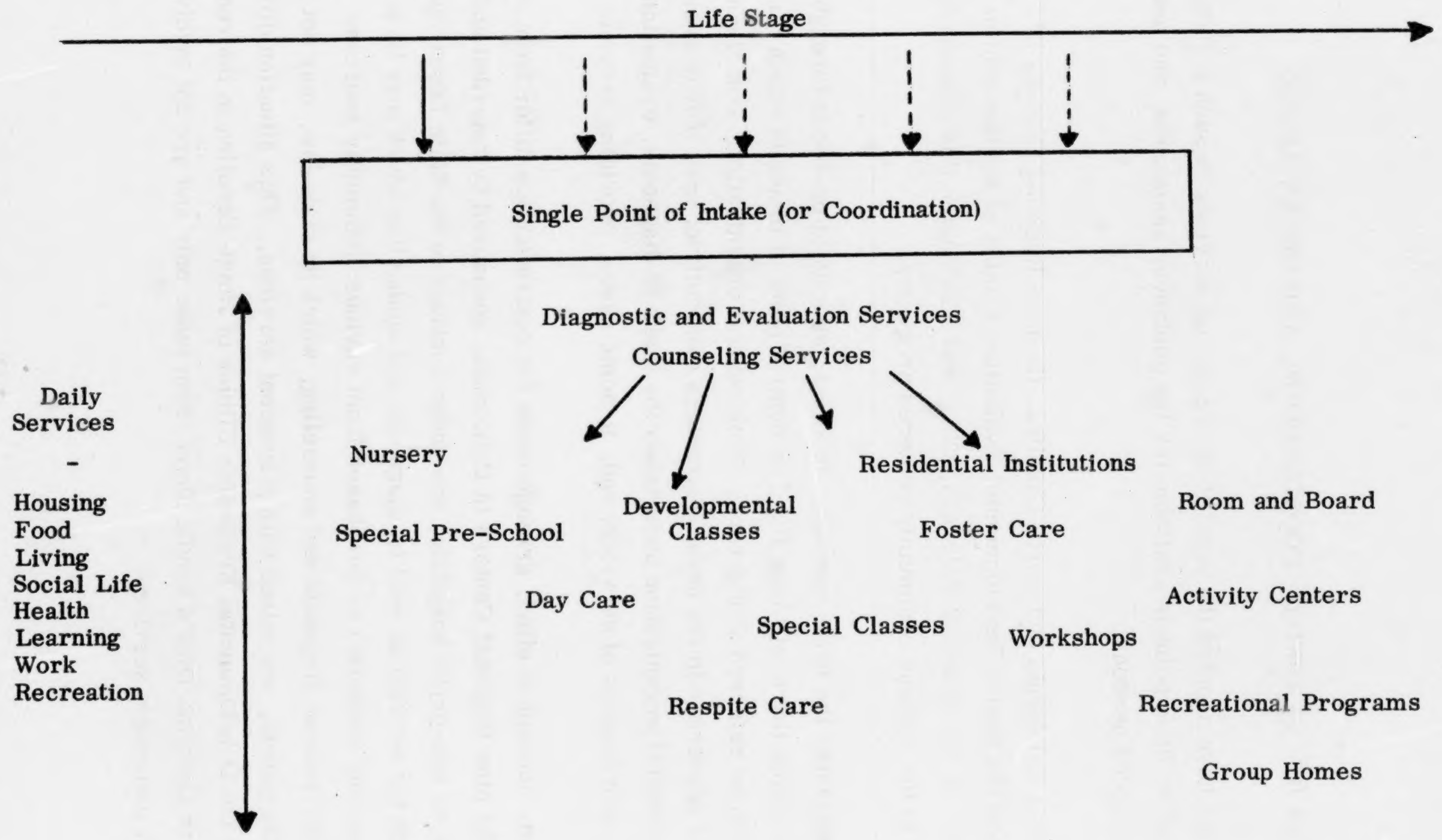

Life Stage
Single Point of Intake (or Coordination)
Diagnostic and Evaluation Services
Counseling Services
Daily Services
-
Housing
Food
Living
Social Life
Health
Learning
Work
Recreation
Nursery
Special Pre-School
Day Care
Developmental Classes
Respite Care
Special Classes
Residential Institutions
Foster Care
Workshops
Room and Board
Activity Centers
Recreational Programs
Group Homes

Figure 2 - Concept of Providing Care

The twelve Developmental Evaluation Clinics of North Carolina provide the greatest state coverage for service of this type than any of the other states. Where the Regional Centers of California are wholly funded by the State, the DEC's of North Carolina are 65% funded by the federal government and 35% supported by the state. In neither case do local governments or communities pay for these services. The total budget of $700,000 for all of the Developmental Evaluation Clinics, which is approximately one-tenth of the total budget for the Regional Centers, reflects the differences in the services provided by the two organizations.

In the remaining three states, diagnosis and evaluation tasks are performed by independent organizations. These are purchased by the various community groups depending upon their authority and interest to do so.

The single point of intake concept focuses primarily on the mentally retarded person's need for special services in the community. Although many caseworkers and counselors, as individuals, seek out a relationship for the mentally retarded person with the general community, state programs mostly disregard the interaction of the individual with regular or general services. The primary focus of programs lies with providing parents with alternatives to placement in state institutions or, such institutional placement having been made, with community placement possibilities. State programs, for the most part, are complete only up to this point. Normalization beyond community placement; e.g., gradual integration into the overall society, if at all possible, is not emphasized in any one of the states.

A fairly uniform failing among states is their lack of detailed scrutiny of the daily cycle of care provided to a mentally retarded individual once that person has been placed in a community facility. The burden of guaranteeing a daily, comprehensive program for the individual rests with the caseworker or counselor but standards and guidelines demanding comprehensive coverage are generally lacking. A sometimes valid complaint of institutional workers is the loss in care given to a person when that person transfers from a state facility to a community residence.

The various organizations responsible for the central or single point of intake are dependent on the availability and the quality of both general and special services in their area of jurisdiction. In this regard their choices of services are sometimes severely limited by both the type of services available and the specific capabilities of those individuals providing services. In some areas this has become a matter of great concern for the reason that it is the facility, for the most part, that is licensed in accordance with health and safety standards. Accreditation requirements for operators of community facilities are generally lacking.

The various state plans for providing comprehensive service to the mentally retarded called for an array of services or service needs based on this concept. Planning programs started in the early 60's and have intermittently reappeared throughout the years.

Figure 3 shows the relationship of planning to the implementation and evaluation processes. The vertical, dotted lines are inserted between planning and implementation to illustrate the fact that legal limitations and lack of appropriations very often cause interruptions between the desired interaction of the planning process and the implementation of plans.

If the planning process is to be effective, it is generally agreed that planning, implementation, and evaluation are indivisible and that the flow between them should be continuous. If plans are to be effective, it is also generally agreed that those charged with the responsibility to plan should, in some way, be provided with the authority to carry out their prescriptions for service. Having this authority, it is then incumbent on the planners to hold down planning efforts to reasonable proportions of total costs.

Among the five states, North Carolina and Ohio have developed the most durable state plans for the mentally retarded. North Carolina started much earlier than Ohio in this venture. Its original state plan, published in 1965, has lasted longer than the plans of any of the other states. This is due perhaps to the fact that the North Carolina Council on Mental Retardation has become a nearly-permanent component of the state government while most other planning councils have been ad-hoc units.

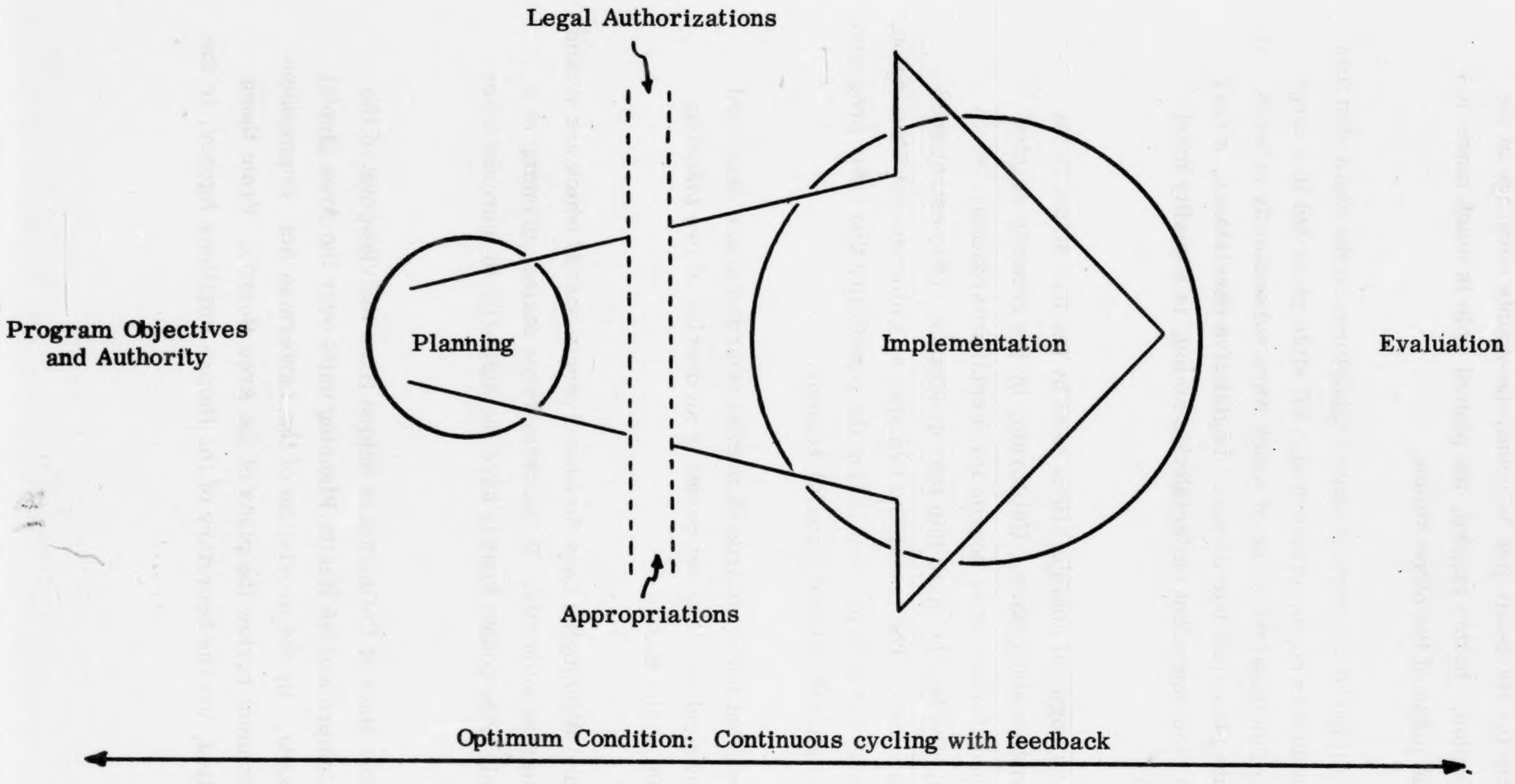

Legal Authorizations
Program Objectives and Authority
Planning
Implementation
Evaluation
Appropriations
Optimum Condition: Continuous cycling with feedback

Figure 3 - The Planning - Implementation Cycle

Ohio's state plan is notable for its detail and its county-by-county coverage of the needs of the mentally retarded. In this regard, the plan of Ohio is much more of a working document than the plans of the other states.

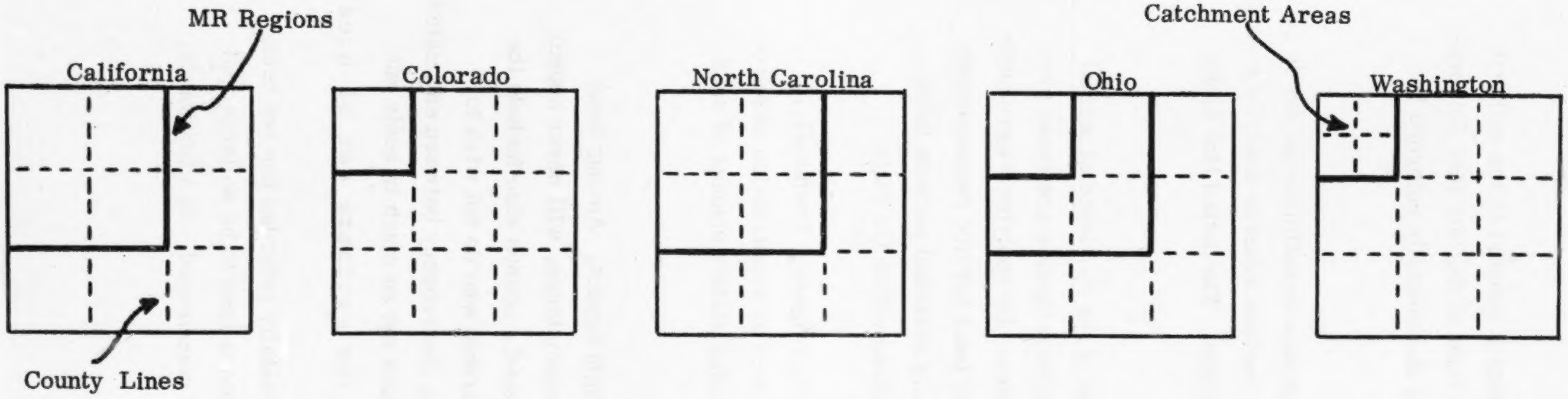
In most cases, the commitment of the various state legislatures to the state plan was not as unanimous as the planners hoped or expected. All state plans led to a large number of legislative recommendations some of which were subsequently refused. At this point many of the state plans fell into disuse. Legislative persistence, a very necessary ingredient of a plan dependent on legislative action, is a quality most evident in North Carolina.

Figure 4 shows the various regional configurations used by the five states in the development of comprehensive state plans. California, by the recently enacted Lanterman Act, established thirteen area boards for mental retardation. North Carolina, by comparison, divided the state into four quadrants. Ohio established fifteen mental retardation zones. The remaining two states, Colorado and Washington, followed county lines except that both are now facing the possibility that their programs will have to comply with state established planning regions.

Ohio is unique in the sense that county boards of mental retardation are mandated and planning zones are prescribed. The net result is an overlay of two planning groups covering each point in the state.

Of the five states, Ohio and Washington have mandated county boards which are vested with a revenue and expenditure authority. In the other three states, planning is a paper authority only. Only Ohio county boards have the authority to increase taxes to meet financial needs.

The planning function in the State of California is unique from the viewpoint of the authority given to local Comprehensive Health Planning units over the Area Mental Retardation Planning Boards. By the provisions of the Lanterman Act, Comprehensive Health Planning units must review the plans of the Area Boards. From there the plans must be submitted, via the Secretary of the Human Relations Agency, to the


MR Regions
Catchment Areas
California
Colorado
North Carolina
Ohio
Washington
County Lines

58 Counties MR optional in County	63 Counties MR optional in County	100 Counties MR optional in County	88 Counties MR mandated in County	39 Counties MR mandated in County
13 MR areas	(11 State regions)	4 MR regions	15 MR zones	(13 State regions)
(25 Coordinating Councils)	(23 Community Centered Programs)	83 County Boards	88 County Boards	39 County Boards

Figure 4 - Regional Configurations

State Health Planning Council. What makes the arrangement unusual is the authority given to what is substantially a health unit especially in light of the fact that Comprehensive Health Planning supports very few programs for the mentally retarded in California.

Figure 5 illustrates the basic method used by planning groups to estimate the needs of the mentally retarded. The solid line connecting the various squares describes the sequence of estimating most often followed by the states. The dotted line along the upper squares marks those sequences rarely used.

All states start their planning sequence with an estimate of the incidence of mental retardation in the state. The most commonly used incidence figures are those prescribed by the American Association on Mental Deficiency. By applying a percentile factor to a given age-range population, the states derive total service requirements. From these figures they subtract the numbers of mentally retarded persons being served. The net figure is the estimate of need for services within the state.

Some states add a newborn, or new population, rate to this figure. Eventually, staffing requirement, cost estimates, and other items such as construction requirements evolve from these estimates based on that particular state's concept of care for the mentally retarded.

The dotted lines describe the losses that any system might expect. Among these should be included those individuals who, under any circumstance, will never appear for services or who are overlooked in the service process. Losses also include the individuals placed in private residential facilities by parents who do not wish to solicit state services. Whatever the reason, there is a discrepancy between estimated and actual needs. The significance of the two figures lies not so much in costs but rather in the fact that the credibility of the estimate can be questioned

The percentile method of estimating the needs of the mentally retarded has not been completely effective in most of the states. Final estimates tend to be so large that the legislatures are sometimes immobilized instead of encouraged. In a few cases,

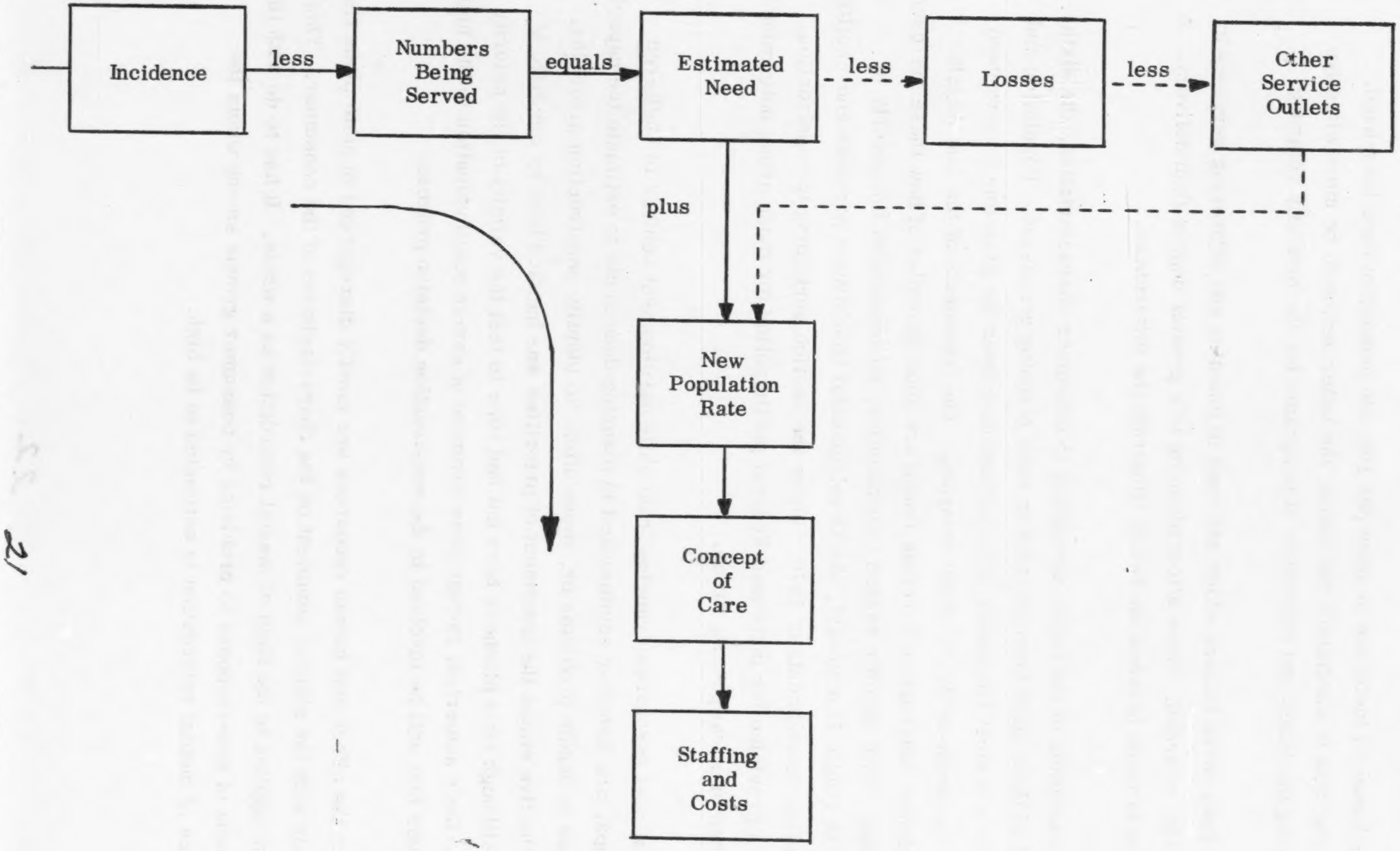

Incidence
less
Numbers Being Served
equals
Estimated Need
less
Losses
less
Other Service Outlets
plus
New Population Rate
Concept of Care
Staffing and Costs

Figure 5 - Estimating Program Requirements

estimates based on incidence or need per 100,000 population have been used. Although the data is essentially the same, the latter seems to be more effective in conveying the intent and objectives of programs for the mentally retarded.

Figure 6 lists seven factors which are used in planning and delivering services to the mentally retarded. Some affect planning to a greater degree than delivery. A distinction is made between the two to illustrate the differences.

With the exception of the factor pertaining to consumer characteristics, the sixth item, all of these have been included in state planning processes. Population and economics are most frequently stressed and have been the principle factors used to gauge the needs of the mentally retarded. The documents of the Los Angeles County Mental Retardation Services Board are good examples of how these are used in planning. With specific regard to economics, an adjustment for poverty is included in Public Law 91-517, the Developmental Disabilities Services and Facilities Construction Amendments of 1970. Under the section pertaining to construction, there is a provision for increased Federal participation for those areas determined to be urban or rural poverty areas.

Organizational resources, ranging from child development centers to sheltered workshops, are listed or summarized in planning documents to estimate the capacity of an area to handle problems or, more often, to identify construction priorities. Among the five states the treatment of priorities was handled best by the State of Ohio. Although Ohio planners have not had time to test the validity of the priority indexes, their numerical ratings show promise of easier communication to the many individuals that will be involved in the construction decision process.

A note to the effect that human resources are mostly disregarded in state plans ties in closely with the similar comment on the characteristics of the consumer. This comment applies to the field of mental retardation as a whole. It has to do with the phenomena of non-response to problems by consumer groups among whom the incidence of mental retardation is estimated to be high.

Planning & Planning Coordination	Factors	Delivery of Services
Not a major problem by itself.	Land Area	Wide area coverage causes problems.
Affects costs and determines points of delivery.	Population	Services difficult to deliver to rural areas and transient populations.
Share formulas and incidence rates adjusted for low income areas.	Economics	Difficult to set up facilities in low income areas.
Not listed as a priority problem in most State plans.	Human Resources	Professionals cluster in metropolitan and near metropolitan areas.
Inventory problems.	Organizational Resources	Rural and low income areas lack specialized facilities.
Mostly overlooked in State documents.	Consumer Characteristics	Minority groups, migrants, and poor are difficult to reach.
Considered in two of the five states.	Transportation	Free transportation provided for handicapped.

Figure 6 - Key Factors in Planning and Delivering Service

All states are confronted with the perplexing problem of how to deal with high incidence areas. In program plans, this problem is spoken of in terms of outreach. In clinical programs, it is referred to sometimes as high risk. It is now becoming apparent that the solution is complex and that casual treatment of the problem in planning documents will not be adequate.

On the delivery of services side of Figure 6, some comments are included to point out the fact that delivering services to the mentally retarded is a problem distinct from planning. All states have made commendable progress during the last ten years in delivering services to areas of high population concentration. However, proportionately more persons are being provided with service in these areas than in poverty pockets, migrant camps, and rural districts. Although some of these inequities can be resolved with increased funds, there is reason to believe that the social problem is inadequately understood and that allowance should be made for more experimentation by service groups.

The subject of resources is discussed further in Figure 7. Facilities and services, both organizational and personal, are included in this category.

Every state, regional, county, and organizational plan includes some provision for the compilation of resources in an area. These include the entire array of services that might be required by a mentally retarded child or adult during any life stage. Facilities and services include special resources such as residential institutions, sheltered workshops, activity centers, and the like. General services include voluntary organizations and facilities such as hospitals and schools.

Inventories of resources are numerous. The inventories vary from deep compilations of actual services available to very casual surveys of capabilities. The Ohio plan contains an inventory which is more thorough than those of other states. It serves the purpose of identifying areas with gaps in capabilities, however, it does not, nor was it probably meant to, serve as a resource directory for the state. In terms of overall statewide directories, the best compilation, supported by the Department of Health, is the Colorado directory of services. In the other states, inventories and

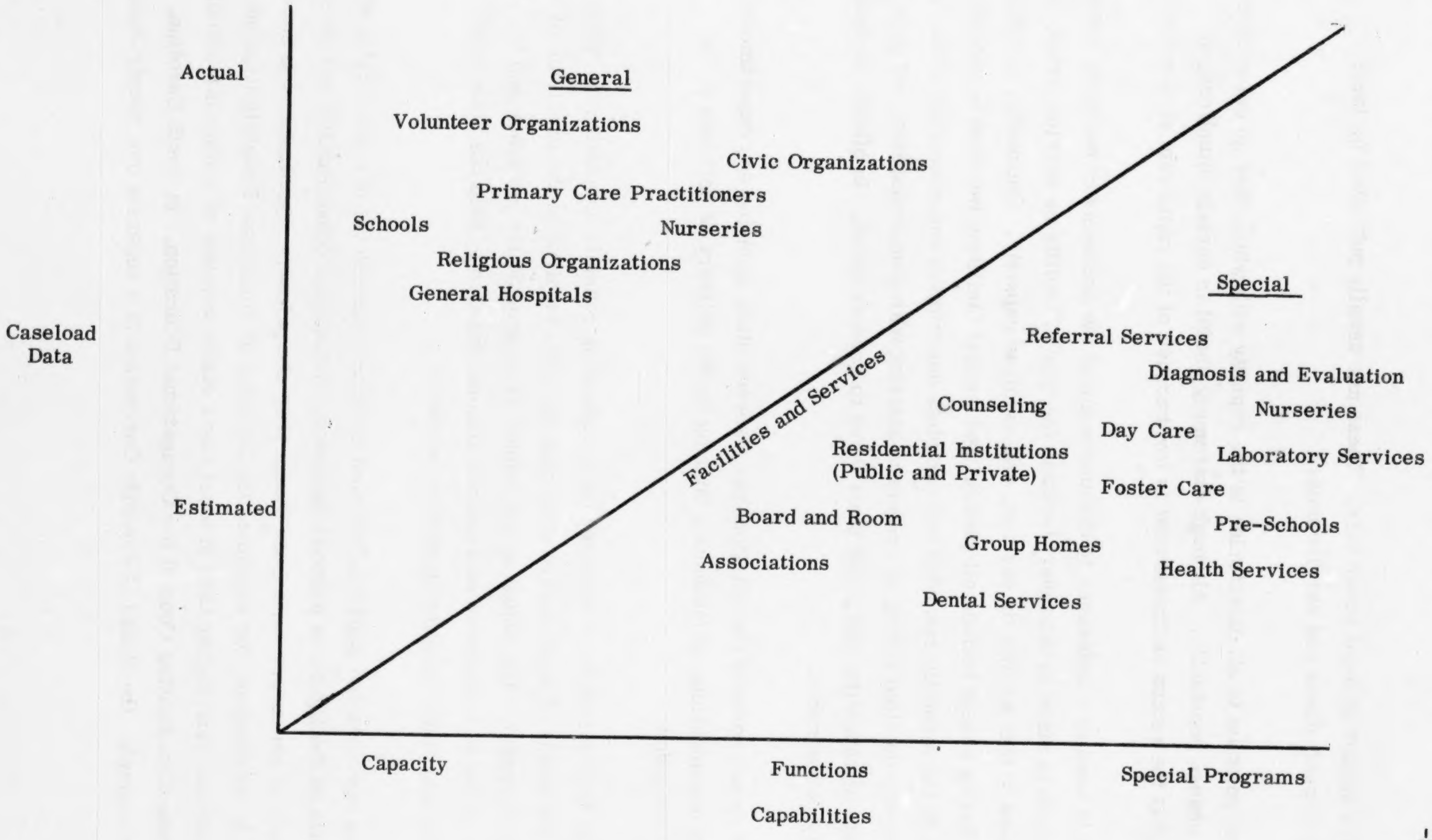

Actual
General
Volunteer Organizations
Civic Organizations
Primary Care Practitioners
Schools
Nurseries
Religious Organizations
General Hospitals
Caseload Data
Special
Referral Services
Diagnosis and Evaluation
Counseling
Nurseries
Day Care
Facilities and Services
Residential Institutions (Public and Private)
Laboratory Services
Foster Care
Estimated
Board and Room
Pre-Schools
Group Homes
Associations
Health Services
Dental Services
Capacity
Functions
Special Programs
Capabilities

Figure 7 - Resources

directories appear in local areas only. These are usually published by local voluntary organizations and service units.

A problem common to all directories is the rapidity with which they go out of date. Listings change constantly. Although extremely useful in certain situations, it appears that the return on investment is low because of the rapid rate of obsolescence.

Figure 7 is used as a reference to discuss some of the problems of resource listings. A distinction is made in this chart between the type of facility or service listed, the capabilities of that facility or service, and caseload capacity. Optimally, a comprehensive listing should include all general and special facilities involved in providing services to the mentally retarded and complete descriptive and numerical data. A progressively detailed listing is preferred starting with comprehensive, but generalized, statements of capability and going from there to greater detail. In effect, an updating capability is desirable.

Figure 8 shows some of the relationships between state agancies and departments and local organizations which have a bearing on the delivery of services to the mentally retarded.

All states had or still have advisory or coordinating councils consisting of, among others, the heads of state departments and agencies involved in the problems of the mentally retarded. The object of the council is to provide the governor and the legislature with broad statements on required actions and also to help the state avoid inequities and discontinuities in service ventures.

The state agencies and departments most involved in problems of the mentally retarded are shown on the figure as primary agencies. Vocational rehabilitation and corrections are shown as secondary units even though they are primary organizations in some states. In Washington, for example, the Division of Vocational Rehabilitation has an organizational rank higher than in most other states because of a state law establishing a separate Coordinating Council for Occupational Education. In North Carolina, as another example, the Board of Juvenile Correction is a separate unit deeply involved

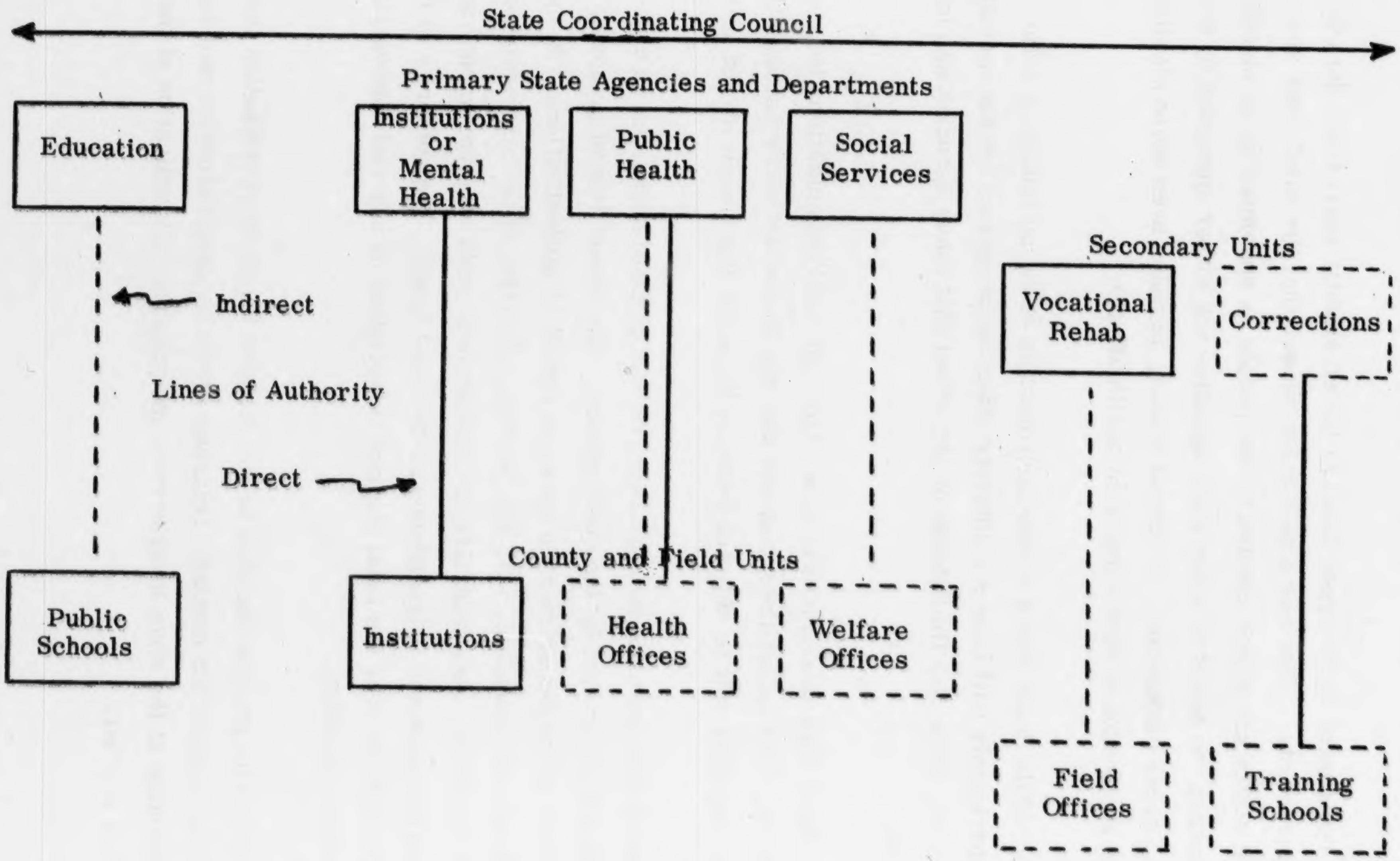

State Coordinating Council
Primary State Agencies and Departments
Education
Institutions or Mental Health
Public Health
Social Services
Secondary Units
Vocational Rehab
Corrections
Indirect
Lines of Authority
Direct
County and Field Units
Public Schools
Institutions
Health Offices
Welfare Offices
Field Offices
Training Schools

Figure 8 - Relationships of State and Local Organizations

in problems of the delinquent retarded. For the most part, however, both of the latter are subordinate units of other departments.

The educational component at the upper level is shown slightly apart from the other agencies and departments. This was done for the reason that the chief state school offices of all five states are either elected by the people or appointed by an elected school board whereas the heads of other state agencies are either appointed by the governor or are career employees. A second reason, perhaps even more significant, is the traditional separation of education from health affairs.

There is probably little doubt that a closer coordination of the activities of state agencies and departments will have a salutatory effect on programs for the mentally retarded. However, there are limitations on the effect that these agencies can have on local activities.

Connecting lines have been drawn between the state and local organizations to illustrate this point. The dotted lines indicate that the line of authority between the state agency and the local unit is indirect whereas the solid lines show direct authority.

Taking the situation that prevails in most Departments of Institutions, as an example, state institutions are controlled by the state agency. The direct line of authority allows the Director of the Department to speak on behalf of all institutions. In the case of Departments of Education, with the possible exception of the state-dependent system of North Carolina, local districts are independent units of government having a financial authority and some independence at the local level. The authority of the chief state school officer over the local district is specified by law and appropriation than by direct communication.

These lines of authority provide the clue to two distinct levels of coordination that are required if services to the mentally retarded are to be comprehensive and continuous. Coordination at the state level serves one purpose. Coordination at the local level serves another.

The County Boards of Mental Retardation of Washington and Ohio appear to be the closest to solving the problem of coordination at the community level. In Ohio the seven member county boards are appointed by the board of county commissioners. The boards must include the probate judge or his delegate and at least one parent of a mentally retarded person. In Washington, the nine to fifteen members appointed by the Board of County Commissioners include representatives of public, private, and voluntary organizations and local governmental units which participate in programs for the retarded. Private citizens knowledgeable or interested in programs for the mentally retarded are also included.

SECTION IV - STATE PROGRAMS

The five states being studied cover a wide range of terrain differences and vary considerably in terms of population and population distribution. They are not too far apart, however, in their organization of services for the mentally retarded. Functional assignments to the various state departments and agencies, for example, are very much the same from state to state. Concepts of care have a superficial similarity. Where they seem to differ the most is in the numbers of mentally retarded being served for any category of care such as residential placement, special classes, and community training.

California, the largest of the five states, 780 miles in north-south length, is marked by deserts, fertile plains, and the high mountains of the Sierras. State programs, aimed at major population centers, have yet to disperse to the more sparsely settled areas or to handle effectively the inner city clusters where problems and needs are critical. The sheer size of the State and the uneven distribution of population appear to have a major effect on programs.

Colorado, best known for the Rockies running through the central third of the State, has the advantage of population concentration in the eastern third of the State. This advantage turns into a disadvantage on the western slopes where population is dispersed and where no major city exists as the hub of activity in that area. Limited revenues account for many of the difficulties of the State in mounting special programs for the mentally retarded.

North Carolina, the State with the lowest per capita income and the only eastern seaboard state being studied, has a terrain profile ranging from the tidewater region along the Atlantic, to the central mesa, to the rugged Appalachian Mountains on the west. The Piedmont mesa has most of the conditions favorable to programs for the mentally retarded - concentrated populations, human and organizational resources, and comparative wealth - while most of the unfavorable conditions exist along the eastern and western sections of the State. North Carolina's major problem lies in the area of providing vigorous services to the isolated, poor community. Of all the states being studied, North Carolina provides the broadest spectrum of services to the mentally retarded and, in many categories of services, reaches the largest number of persons per 100,000 population.

Ohio, with a terrain surface best described as one rolling plain and lacking any distinctive geological feature, is the most compact of the five states being studied. Perhaps because of the State's large number of small county units, services to the mentally retarded in Ohio are evenly distributed compared to service distribution in the other states. Ohio has, by far, the most vigorous community centered programs for the mentally retarded of all the five states.

Washington, the most northwesterly state in the nation, has a terrain profile somewhat similar to that of Colorado except that the area lying beyond the central Cascades is not as rugged as that of the western slope of Colorado. Washington's population is concentrated in a north-south carridor paralleling Puget Sound but, unlike Colorado, there is a major city in the eastern section of the State. Distribution of services to the isolated community is one of the major problems of the State. Washington, with a history of organizational interest in the problems of the mentally retarded older than most states, has not moved as fast as other states in community centered programs. However, of all the states being studied, the residential institutions of the State are least isolated from the community. Where the line of demarcation between the institution and the community in other states tends to be very sharp, the relationship of the two in Washington is not as severe. In this regard the institution is much more of a local venture than in the other states.

In terms of area, population, and income, differences between the states range from the smallest (Ohio) being one-fourth the size of the largest (California) to the most sparsely settled (Colorado) having one-thirteenth the number of persons per square mile as the most densely populated (Ohio).

Figure 9 lists some of the general characteristics of each state all of which have some bearing either on planning programs for or delivering services to the mentally retarded. All general indicators are not listed; however, these illustrate the fact that there is a certain scattering of rank. As these and other indicators are used to gauge what a state is or should be doing on behalf of the mentally retarded, the impact of each in that particular state should be kept in mind before any programs priorities are established which will, in some way, have a bearing on the delivery of services.

California ranks first in land area followed by Colorado. Differences in size among Ohio, North Carolina, and Washington are not as significant as the difference between these three andColorado and California. The size of California, coupled with the fact that public transportation in that state is minimal, doubtlessly has a major effect on service programs in that state. Interestingly, Ohio, which is comparatively compact, included transportation (or access) as a criterion in planning whereas California, which has a major transportation problem, does not.

Ohio ranks highest in terms of population density. California, with less than half the number of persons per square mile, might be in a favorable position to deliver services to the mentally retarded if it were not for the fact that distribution of population in California is extremely uneven. In terms of uniformity of population distribution, Ohio is in the best position; North Carolina ranks second; the remaining three states share the problem of uneven distribution.

The last two items on the figure, gross income and per capita income, are one measure of the states' financial ability to support programs for the mentally retarded. The differences between North Carolina and California are significant. California, being the largest, most populated, and wealthiest state would appear to have a distinct advantage over North Carolina. It is interesting to note how ranking changes in terms of service per 100,000 population and how North Carolina has been able to exceed what appears to be a severe financial limitation in its ability to provide services.

Figure 10 lists state programs in the areas of institutional and educational services, the two major services in any of the states. Community placements and rehabilitation

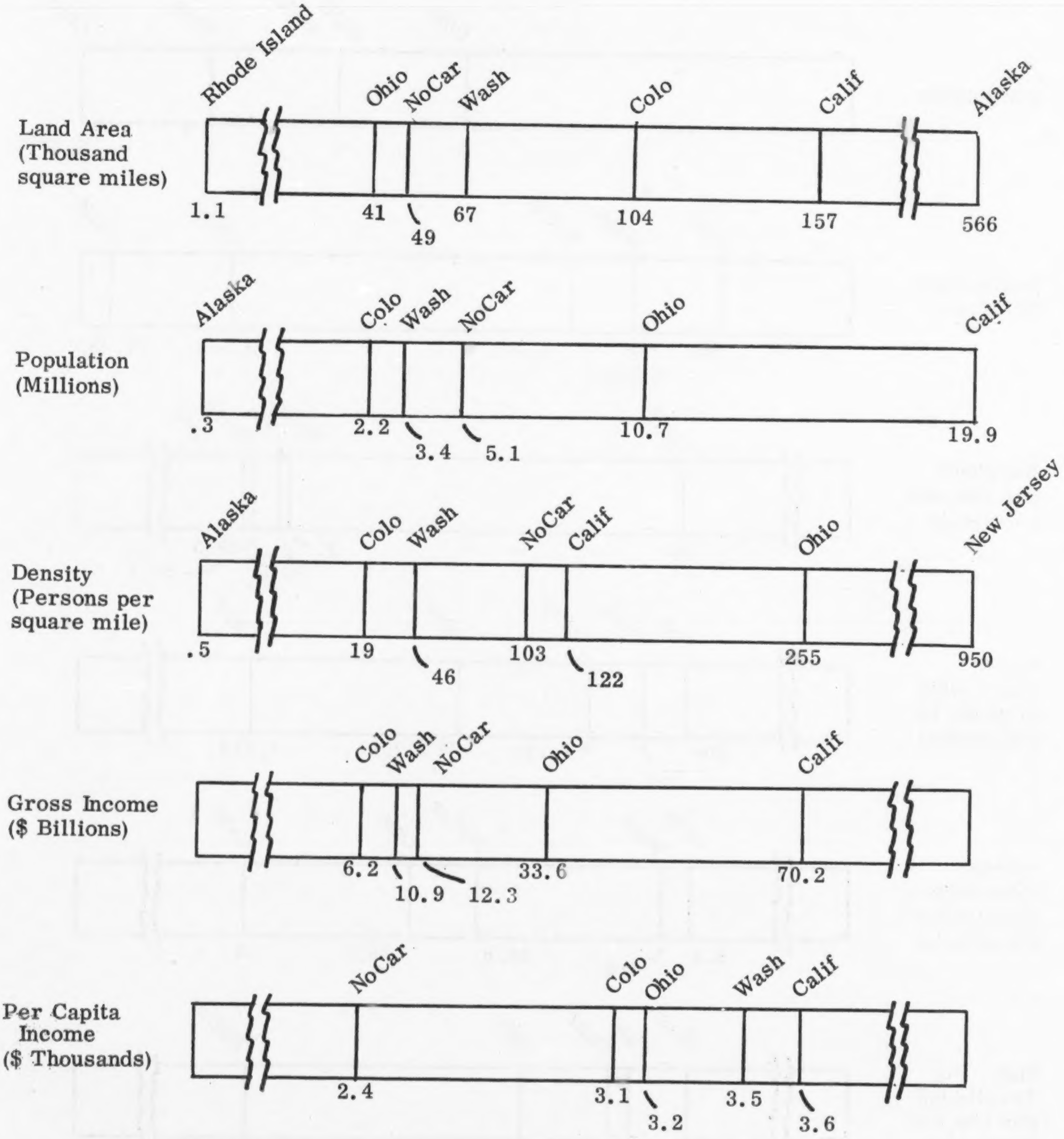


Figure 9 - Area, Population, and Income

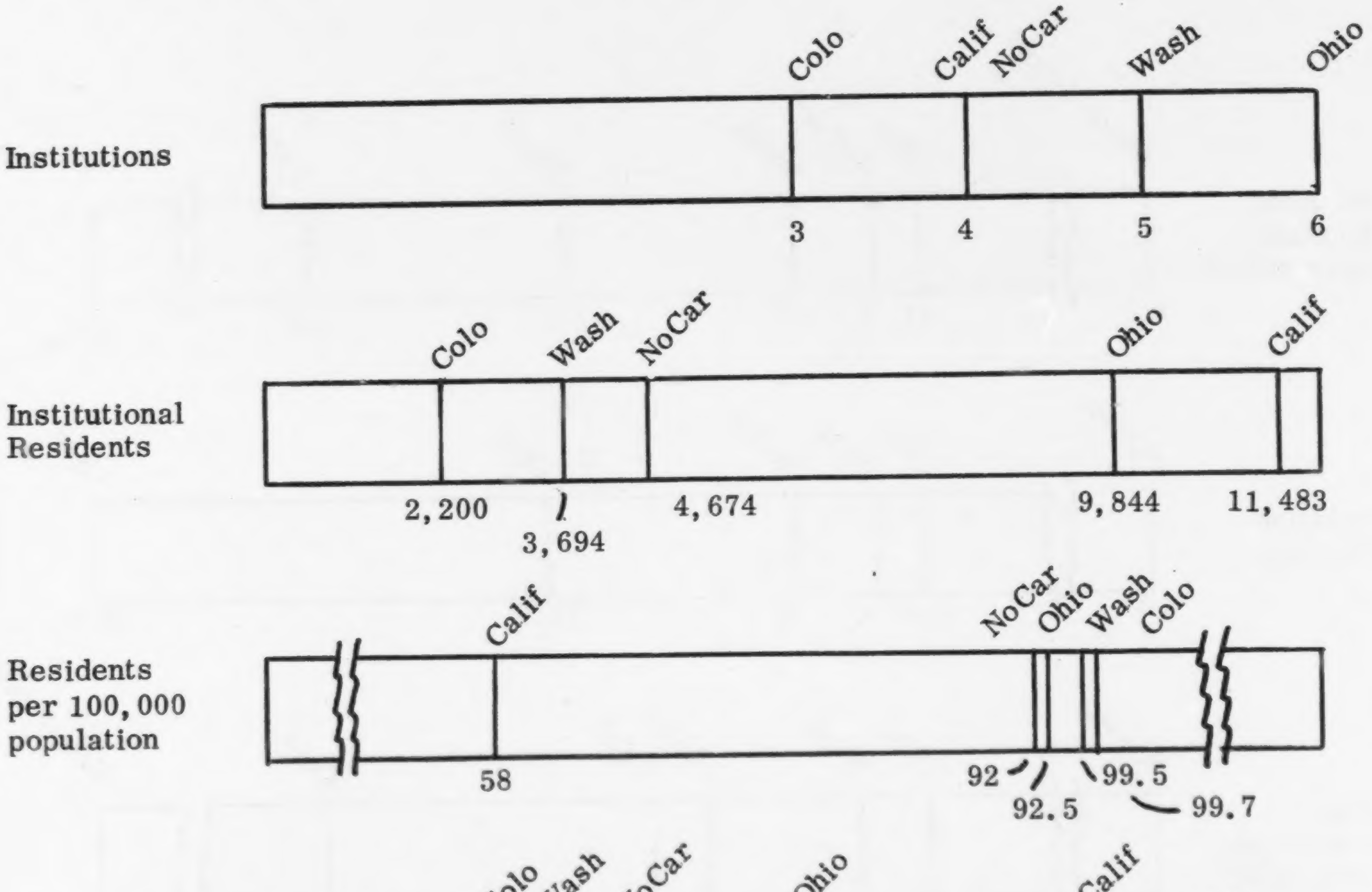


Figure 10 - State Services in Selected Categories

services are not listed because of the incompatibility of these data from state to state.

The rankings of greatest interest appear on the third and the last line, residents per 100,000 population and special education enrollment per 100,000 population. The low ranking of California in terms of residents per 100,000 population is most noticeable on line three. California's drop to third place in terms of special education per 100,000 population is curious particularly in light of the fact that California is the only state among the five with mandated education for the educable and trainable mentally retarded.

The low ranking of California in residents per 100,000 population is somewhat offset by the fact that California has the largest number of community placements among all the states. However, the public residential census and community placements, combined, only total 90 per 100,000 population which is still lower than North Carolina's census for state institutions only.

It is interesting to note that Ohio, with the greatest number of institutions is the only state with a plan to construct new institutions and to decrease significantly the number of residents per institution. Of all five states, Ohio is the only state which established a fixed goal of 100 residents in residential facilities per 100,000 population and is working toward that goal. All others have plans to decrease the total number of residents in state institutions but have not fixed an overall goal of what the ratio of institutionalization, public or community, should be. The various state reports, which follow, elaborate on the data contained in these two figures.

1. CALIFORNIA

General Characteristics of the State

Area, Population, and Income

California, the third largest and most populated state in the nation, is bounded on the north by Oregon, on the east by Nevada and Arizona, on the south by the Mexican territory of Baja California, and on the west by the Pacific Ocean. Its north-south length is 780 miles. It varies in width from 150 to 350 miles. Its 1,200 mile coastline represents almost one-tenth of the total coastline of the United States.

In size, California ranks third behind Alaska and Texas among all states with a land area of 156,537 square miles. It ranked first in total population in 1970 with almost 20 million inhabitants. It dropped to 14th place in terms of population density with approximately 127 persons per square mile.

The average density per square land mile is based on an average of extreme high-low variations. The Los Angeles-Long Beach area has a population density of 1,686 persons per square mile. Eight counties have less than five persons per square mile.

Topographically, northern California is best known for the Great Valley consisting of the San Joaquin Valley, south of San Francisco, and the Sacramento Valley, running to the north of San Francisco. The Valley extends 400 miles north from the Tehachapi Mountains to the Oregon border and has an average width of 40 to 50 miles. It is bounded on the west by the Coast Range and on the east by the Sierra Nevadas.

Southern California lies south of the Tehachapi dividing line. Covering one-third of the State's area, it consists of a series of valleys and coastal areas broken up by the Sierra Madre, San Bernardino, Santa Ana, and numerous minor mountain ranges, which separate the coastal valleys from the Colorado and Mojave deserts. The great Coachella and Imperial Valleys, lying inland of the San Jacinto and Santa Rosa Mountains, extend three-fourths, the length of southern California.

In 1967 there were fourteen Standard Metropolitan Statistical Areas in California. In order of size the metropolitan areas were Los Angeles-Long Beach, San Francisco-Oakland, Anaheim-Santa Ana-Garden Grove, San Diego, San Bernardino-Riverside-Ontario, San Jose, Sacramento, Fresno, Oxnard-Ventura, Bakersfield, Stockton, Santa Barbara, Vallejo-Napa, and Salinas-Monterey. The first ten ranked among the 100 largest metropolitan areas in the United States. The first five had populations of over 1 million each.

The metropolitan areas are evenly divided between northern and southern California. Seven lie north of the Tehachapi's and seven lie to the south. Four of the northern metropolitan areas are located in the Great Valley. There are no Standard Metropolitan Statistical Areas in the southern Coachella or Imperial Valleys.

There is no major population center between Sacramento and the Oregon border more than 200 miles to the north. The Siskiyou Mountains, forming a natural barrier between California and Oregon, lie to the northwest. In the northeast, lava-bed plateaus are hemmed in by mountain spurs. Both are sparsely settled areas.

Except for the city of San Francisco, all of the population centers are sprawling cities covering large land areas. The Los Angeles-Long Beach metropolitan area covers an area of 4,069 square miles. Within its boundaries there is no one population cluster forming a hub toward which people and services gravitate. There are random settlements scattered throughout the area each forming a loosely defined community. This mosaic pattern of population is typical of most of the California multi-city, metropolitan areas.

In 1967 California ranked first nationally with a gross personal income of $70.2 billion. It dropped to seventh place with a per capita income average of $3,665 which was higher than the national average of $3,159 and the average of any of the five states being studied.

Local Governments and Districts

California, with 3,864 governing units in 1967, ranked fifth among the states in numbers of local governments. The 58 counties, 400 municipalities, 1,239 school districts, 64 hospital districts, and 53 housing authorities are included in this count. California law provides for a variety of other special districts, most of which have no direct bearing on services to individuals. California is one of the 29 states without any local township form of government.

Among the five states being studied, California has the largest number of local governments. Ohio is second with 3,283. Colorado has the fewest with 1,252. In terms of the number of local governing units per 100,000 inhabitants, however, Colorado takes the lead with 63.4. California, with 20, drops to fourth place and is outranked only by North Carolina which has 15 local governments per 100,000 inhabitants.

All school districts, except two, are governed by elected boards or trustees. The districts in Sacramento and San Francisco have boards appointed by the mayor or the city council and ratified by the voters. Most school boards determine their own fiscal requirements and the counties levy and collect taxes found to be required. Bond issues for school district purposes are subject to the approval of the electors. All school districts in California, except the Los Angeles school district, are independent units. The Los Angeles school system is a dependent unit of the county government.

There are 306 local governments with territories extending into two or more counties. One hundred twenty-nine school districts extend into more than one county; 24 have territories extending into three or more counties.

California, although larger in size and more populated than the other four states, has fewer counties than all states except Washington. One-fourth of the 58 counties have populations in excess of 250,000.

By 1969 the number of operating school districts in California had decreased to 1,095. The decrease represented a 46% negative change in districting during the period between 1952 and 1969. During that same time, the other four states also showed a decrease in the number of school districts. Colorado showed a marked 86% decrease. Ohio followed with a 55% decrease. California was third. Washington was fourth with 40%. North Carolina, with few school districts in 1952, dropped a nominal 9% in that period of time.

Revenue and Expenditures

California's gross general expenditure of $4.5 billion in 1967 was the highest nation. Of this amount, 51% was distributed to local governments. By comparison, New York state, with a 10% lower general budget, expended $3.2 billion to local units of government or $400,000 more than California. In terms of the individual intra-governmental support, expenditures resulted in a per capita annual expenditure of $178 in New York and $144 in California.

Per capita expenditures for education in California were $66 compared to $96 in New York. The sharp difference can be traced partially to the fact that California welfare absorbed 34% of the total intra-governmental budget compared to 25% for New York and also to the large California highway expenditure of 10% of the local budget compared to less than 4% for New York.

In 1968 the total revenue for the State was $5.3 billion compared with a total expenditure of $5.0 billion. Ohio, with one-half the population of California, accumulated revenues of $3.2 billion compared to expenditures of $2.9 billion.

California expended $18 million for federal funds on community health services and maternal and child health in 1969 or approximately 7% of all federal funds expended that year in those categories of spending. Major expenditures consisted of $602,000 for comprehensive state health planning, $726,000 for areawide health planning, $4.6 million for comprehensive public health services, $5.8 million for health services development, $1.2 million for migrant health, $2.2 million for maternal and child health services, and $2.6 million for crippled children's services.

New York State federal expenditures in these same categories for 1969 were $21.6 million or $3.2 million more than were expended in California. Among the five states being studied, federal funding in these categories favored the less populated states. Ohio, with 10.6 million inhabitants, expended $11.4 million. North Carolina, with one-fourth the population of California, expended $7.8 million. Washington, with 3.4 million inhabitants, expended $3.7 million. Colorado, with one-tenth the population, expended $4.2 million.

On aid to families with dependent children, California total expenditures in 1969 were $606 million of which 52.6% were federal funds, 26.6% State funds, and 20.8% local funds. The total number of familes served was 267,000. The total number of children was 721,000. The average money payment per family for the month of June 1969 was $186.25.

During that same period of time Ohio served 61,900 families for an average monthly payment of $158.50; North Carolina, 28,800 families for an average of $113.65; Washington, 22,600 families for an average of $169.75; and Colorado, 15,500 families for an average of $145.60.

On aid to the totally disabled the June 1969 registration for aid in California was 149,000. The total annual expenditure was $227 million of which 50.6% was federal money, 37.2% State funds, and 12.2% local funds. No other state in the nation served more than 62,000 individuals during that same period of time. None of the other four states being studied served more than 29,000 totally disabled.

In terms of general welfare assistance, California's caseload of 41,600 in June 1969 was the highest of the five states but California's average monthly payment was third. Ohio's average monthly payment to general welfare recipients was $98.10 per month; Washington's was $86.85; California, $72.90. North Carolina was lowest among the five with an average montly payment of $28.85. California's gross general assistance expenditures for the year were $35 million.

State Organization

The two primary agencies of the government of California involved in the delivery of services to the mentally retarded are Department of Education (Wilson Riles, Superintendent) and the Human Relations Agency (James Hall, Secretary). The four departments in the Human Relations Agency most concerned with programs for the mentally retarded are the Department of Public Health (Louis Saylor, M. D., Director), Department of Mental Hygiene (Dr. James Lowrey, Director), Department of Social Welfare (John Montgomery, Director), and Department of Rehabilitation (Robert Howard, Director).

Among the five states being studied, California and North Carolina are the only two in which the superintendent of public instruction and the board of education are appointed by the governor. At the school district level, however, California and North Carolina differ in the respect that school districts in California, for the most part, are independent districts while the districts in North Carolina are dependent extensions of the county government. In Colorado and Ohio, the chief state school officer is appointed by the board of education which is elected by the people.

Within the Human Relations Agency the offices assigned to the problems of the mentally retarded are the Bureau of Mental Retardation Services, Department of Public Health (Charles Gardipee, M. D., Chief), Division of Mental Retardation Programs, Department of Mental Hygiene (William Keating, Jr., M. D., Deputy Director), and the Community Services Division, Department of Social Welfare (Richard Middlebrook, Chief). In the Department of Education, the counterpart office is the Bureau for Educationally Handicapped and Mentally Exceptional Children (Dr. Joseph Rice, Chief).

In 1967 a State Health Planning Council was established by an Assembly bill. The bill reflected the requirements of the federal "Partnership for Health Program," P. L. 89-749, particularly Section 314(a), Statewide Comprehensive Health Planning. The Chairman and Vice-Chairman are appointed by the Governor. The executive secretary of the Council (Robert Jackson) is appointed by the Council. The State Health Planning Council advises the Secretary of the Human Relations Agency on the programs of health care in California. The Office of Comprehensive Health Planning, located in the Human Relations Agency, has the responsibility for determining State health goals, State health priorities, and developing an overall comprehensive State plan for health.

All five states have Offices of Comprehensive Health Planning; however, none are as directly involved in the problems of the mentally retarded as the State CHP office or the Health Planning Council in California. The 1969 Mental Retardation bill specifies that mental retardation area plans shall be submitted to the Secretary of the Human Relations Agency for approval and transmission to the Areawide Comprehensive Health Planning Agency and the State Comprehensive Health Planning Countil. Area Board planning procedures are written accordingly.

The State Mental Retardation Program Advisory Board is a new board established by the same Assembly bill. The Board, to be located in the Human Relations Agency, will advise the Health Planning Council, the Secretary, the Governor, and the Legislature on the initiation, coordination, and implementation of programs and projects for the mentally retarded.

Planning and Planning Coordination

The recent history of state planning for the mentally retarded in California can be traced from the federally supported comprehensive statewide plan published in 1965, through various commission studies, to the most recently enacted California Mental Retardation Services Act of 1969, popularly known as AB 225 or the Lanterman Act.

The comprehensive statewide plan titled, "The Undeveloped Resource: A Plan for the Mentally Retarded in California" was prepared by an appointed Study Commission on Mental Retardation. As in the case of the other four states being studied, the document consisted of a series of recommendations dealing with service inadequacies in the State.

In 1966 under P.L. 89-97, the implementation sequel to the federal planning authority, the State received an award of $193,000 for the 12-month period ending March 1967. The State also received a $208,000 continuation grant in 1968. The single agency designated to administer California's mental retardation programs was the Health and Welfare Agency (now the Human Relations Agency) and it was through this agency, with the consent of a Mental Retardation Program and Standards Advisory Board, that programs were contracted through the California Council for Retarded Children.

The first year's programs under P. L. 89-97 included the following six projects:

1. Public Awareness
2. Community Mental Retardation Planning
3. Coordination of Planning of Mental Retardation Facilities (under P. L. 88-164) with Program Planning
4. Development of Services for the Mentally Retarded under the Short-Doyle Act
5. Planning of a new small hospital in conjunction with the University of California Medical School
6. Establishment of a Development Center for Handicapped Minors

The project entitled: "Community Mental Retardation Planning" was funded for a first year total of $27,000. The project involved comprehensive planning in six communities. This project was continued at the level of $137,000 when the Health and Welfare Agency awarded a second year contract to the California Council for Retarded Children.

The eleven community organizations awarded planning contracts by CCRC included local associations for retarded children, coordinating councils, and non-profit organizations. Three of the awards were to local coordinating councils: the Far Northern Coordinating Council in Redding; the Madera, Merced, Mariposa Coordinating Council in Madera; and the Tulare Coordinating Council. A total of 25 coordinating councils, constituting an informal planning and coordination network, were in existence. These councils were funded, in no particular pattern, by county governments, the California Department of Mental Hygiene, Short-Doyle Act funds for Community Mental Health Services, Comprehensive Health Planning, and through federal grants.

In 1968, Spencer Williams, who was the Secretary of the Human Relations Agency at that time, appointed a three-man task force to review the delivery of services to the mentally retarded by the Department of Mental Hygiene. The members of the task force, Dr. Thomas Nelson of the College of Medicine of the University of California, Irvine; Dr. Richard Koch of Children's Hospital of Los Angeles, and Dr. Irving Philips of the Langley Porter Neurophyschiatric Institute in San Francisco, made 26 recommendations on the subject of institutions, residential care, regional centers, and various other matters of interest to both the Department of Mental Hygiene and the Human Relations Agency. In testimony before a Senate committee after the task force report had been published, Dr. Nelson said that the single most important observation made in reviewing the organization of the Department of Mental Hygiene was the lack of overall planning, direction and goals. In their report, the task force recommended that a statewide master plan be developed and updated annually for implementation of the proposals developed by the California Study Commission.

At the same time that the task force was reviewing the service program of the Department of Mental Hygiene, a six-month study was being conducted by the Assembly Office of Research of the California Legislature as a result of a House Resolution submitted by Assemblyman Frank Lanterman. The resolution called for an analysis of the structure of California's mental retardation system with a view toward establishing a framework in which a master plan for the use of various resources might be developed.

Assembly Bill 225, the California Mental Retardation Services Act of 1969, was introduced by Assemblyman Lanterman in January, 1969, and signed into law in September of that same year. The bill provides formal expansion of existing regional centers into a statewide network, the creation of Area Mental Retardation Program Boards, and the development of a statewide plan for mental retardation. The bill went into effect on July 1, 1970.

The bill specified that the Secretary of the Human Relations Agency shall divide the State into areas for the purpose of planning and coordinating services for the mentally retarded. To the extent possible, these areas were to correspond with the existing nine Comprehensive Health Planning regions.

Thirteen planning areas have since been established; two of which - the northwestern and southern areas - correspond with the health planning regions.

Most of the regions in northern California were not changed significantly from those established by Comprehensive Health Planning. The major change was made in the Los Angeles-San Bernardino area. Under Comprehensive Health Planning, the eight-county area embracing Mono, Inyo, San Bernardino, Riverside, Orange, Los Angeles, Ventura, and Santa Barbara Counties was classified as a single area. With a land area of 48,400 square miles and a population of 10.2 million, this area was equal in size and population to the State of Ohio.

Under AB 225 that area, plus San Luis Obispo County, was divided into four mental retardation planning areas. The largest of the four in acreage with a population of 1.2 million is the San Bernardino, Riverside, Mono, and Inyo area covering a territory of 40,427 square miles. The most populated is Los Angeles (4,060 square miles, 7 million inhabitants). The smallest is the Orange County area (782 square miles, 1.4 million inhabitants). The fourth area, consisting of Ventura, Santa Barbara and San Louis Obispo Counties, is the least populated (726,000 inhabitants).

Task forces, consisting of agency representatives and appointed members, were formed to prepare plans for the implementation of AB 225. Task force subjects included area processes and procedures, parental fee schedules, program budgets, area plans, standards and evaluation, and rates.

Members of the thirteen Area Mental Retardation Program Boards have, with some exceptions, been appointed. The bill specifies that each of the areas shall have five members appointed by the Governor and from one to twelve members appointed by the governing bodies of the counties in that area. The single county areas of Los Angeles and Orange, for example, will have board memberships consisting of twelve county and five gubernatorial appointments for a total of seventeen each. The ten county planning area in the vicinity of Sacramento will have a board consisting of one representative from each of the counties and five gubernatorial appointments for a total of fifteen members. The five county area in the vicinity of San Francisco will have a board consisting of two representatives from each of the counties and five gubernatorial appointments for a total of fifteen members.

The bill specifies that the Area Board shall be the mental retardation planning body for the area and shall develop and submit the area plan. The Board shall also have the responsibility for coordinating and encouraging the development of services.

The bill further provides that the Secretary of Human Relations shall develop a statewide plan for mental retardation services based on area plans and a program budget which includes all services for the retarded regardless of the agency which provides them. The object of the state plan is to allow the Administration and the Legislature to consider the programs of all agencies serving the mentally retarded at the same time so that an overview of all services can be obtained and funding priorities developed.

Areas plans, due to be completed on June 1, 1971, will be referred to Comprehensive Health Planning for review and after being adjusted will be submitted to the Secretary of the Human Relations Agency for the development of the State plan. The State plan will be reviewed by the Mental Retardation Board and the Health Planning Council before being submitted to the Governor and Legislature for approval and action.

Area plans may include County and Regional Center plans if a particular county elects to establish such an agency and if that area has or elects to have a Regional Center.

Legislation

The California Mental Retardation Services Act of 1969, introduced into the State Legislature by Assemblyman Frank Lanterman, called for the regionalization of the State into mental retardation planning, coordination, and service territories. The Act, without an accompanying appropriation, went into effect on January 1, 1970. During the first year, effort went into structuring the State into thirteen areas, appointing boards for each of these areas, and generally preparing for the initiation of services. If the financial intent of the Act to transfer funds from various agencies to the regional centers for out-of-home hospital and post-hospital care is followed, the major provisions for service will go into effect on July 1, 1971.

By following this course of action, the Lanterman Act aims to fill many of the gaps in service which lie beyond the duties and powers of agencies and departments of the State government. The admission and discharge procedures of the State hospitals will be affected by the Act; however, other programs such as special classes for the educable and trainable mentally retarded, pre-school compensatory education for the handicapped, and Developmental Centers for Handicapped Minors will continue under the auspices of the original sponsoring agencies.

Under the Act the role of the regional centers will be expanded and the functions of the existing, informal network of 25 coordinating councils will be assumed, to a great extent, by the area mental retardation boards. Under the Act also, local Comprehensive Health Planning agencies and the State Health Planning Council will be drawn into the mental retardation planning procedure.

Selected sections of legislation related to or affected by the Lanterman Act are cited below:

The Short-Doyle Act of 1957

The Short-Doyle Act created a fiscal mechanism whereby counties or cities could provide mental health services and receive reimbursement from the State for a percentage of the cost of care. The original state-local matching formula was 50%-50% less fees, insurance, and other revenue. In 1968 the formula was changed to 75%-25%. Under the new Short-Doyle Act, which became effective on July 1, 1969, the formula was changed to 90%-10%;

the State share being 90%. In 1957, when the Act went into effect, twelve communities received a State appropriation of $786,000 for community mental health services. In 1970, there were 52 communities sharing an appropriation of $53.9 million. It is this Act to which the Lanterman Act refers in the statement that the area plan must include the fullest possible participation by Short-Doyle agencies. This Act supported many of the twenty-five mental retardation coordinating councils which have been in existence in California since the early 1960's.

The New Short-Doyle Act, July 1969

In addition to increasing the State's share of the state-local matching formula, the new Short-Doyle Act specifies that community mental health service will be mandatory rather than elective in counties with populations of 100,000 or more and that a County Short-Doyle Plan specifying services to be provided, both in county facilities and by private agencies and state hospitals by contract, must be prepared annually. Although the county mental health services programs are reimbursed a greater amount, the counties must purchase state hospital care for mentally disordered residents of the county who are in state hospitals. The only residents excluded from this requirement are those who have been judicially committed. The object of the new Short-Doyle Act is to provide a program of services under a single system of care whether those services are provided by community or state facilities.

Regional Centers - Assembly Bill No. 691, 1965

The proposal for a network of regional diagnostic, counseling, and service centers for mentally retarded persons and their families first appeared in a report presented by Assemblyman

Jerome Waldie on behalf of the Subcommittee on Mental Health Services by the Assembly Interim Committee on Ways and Means in accordance with House Resolution 64 of the 1963 General Session. The report stated that the heart of the problem of the mentally retarded lay in the fact that most families who were unable to care for their retarded child at home had no choice other than to place the child in a state hospital. The report focussed on the 2,171 individuals on the waiting lists of state hospitals in April 1963 and particularly the 1,247 who were considered to need not admission but alternative forms of placement or care.

The report quoted public health officials as estimating that ten contracted regional centers could provide service to the waiting list of retarded persons needing service each year. For the first full year of operation the committee's proposal would create a new system for diagnosing and counseling 600-700 new cases and could provide for community care of 700-800 persons who would otherwise require state hospitalization for a cost of approximately $2 million as opposed to a yearly cost of care in state hospitals for 700 patients of $2.4 million - excluding construction costs.

The provisions of the bill, as registered in section 415.4 of the Health and Safety Code, specify that regional centers shall provide and perform or cause to be performed services including, but not limited to, the following:

(a) Diagnosis.

(b) Counseling on a continuing basis. Counseling shall include advice and guidance to any mentally retarded person and his family, to assist them in locating and using suitable community facilities including, but not limited to: special medical services, nursery and preschool training; public education; recreation;

vocational rehabilitation; and suitable residential facilities.

(c) Provide state funds to vendors of service to the retarded, when failure to provide such services would result in state hospitalization.

(d) Maintain a registry and individual case records.

(e) Systematic follow-up of the mentally retarded and reactivation of cases as indicated.

(f) Assist, where necessary, in state hospital placement of the mentally retarded.

(g) Call public attention to unmet needs in community care and services, defining and interpreting standards of community care and services as used by the regional center, and stimulating the community to develop such services as needed.

(h) Maintain a staff according to standards set by the State Department of Public Health.

The Bill further specified that the agency operating a regional center may enter into agreements with parents and others responsible for the care of the mentally retarded to use such amounts as they may be able to pay toward the cost of services for such mentally retarded persons. The Bill ends with the provision that in no event shall there be any charge for diagnosis or counseling.

Guardianship and Conservatorship, Health and Safety Code, Section 416 et seq., 1968

The recommendation of the 1964 Mental Retardation Study Commission with regard to guardianship and conservatorship was adopted by the Legislature in 1968. It appears as Sections 416 through 416.24 of the Health and Safety Code. In effect, the Director of Public Health may be nominated and appointed as either the guardian or conservator of the person and estate or the person or estate of any eligible mentally retarded person. To qualify, the mentally retarded person must be eligible for the services of a regional center or a patient in any state hospital who is admitted from a county served by a regional center. The code specifies that the Director of Public Health may contract with others; e.g., regional centers, for the performance of his functions. It further specifies that the Director's duties shall be performed solely through the regional centers.

Comprehensive Health Planning, Assembly Bill 1567, 1967

Public Law 89-749, the Partnership for Health Program, enacted by the United States Congress in 1966, was the basis for Assembly Bill 1567, which established the California State Health Planning Council. By that same federal authority, nine comprehensive health planning areas were established in the State of California; all of which have been supported under section 314(b) of P. L. 89-749 for organizational activities and two for operational planning activities (NORCOA, the four-county area in the northwest corner of the State, and San Diego, the two-county area on the Mexican border). Section 314(e), which provides federal grants for special areas of need, has been used in California for a statewide rubella program and programs for the mentally retarded.

The original Health Planning Council established in 1967 had thirteen members. In 1969 the membership of the Council was increased to 21 members. Of these, thirteen are appointed by the Governor, three by the Chairman of the Senate Rules Committee, and two by the Speaker of the Assembly. The Directors of the Departments of Mental Hygiene and Public Health are the remaining two members.

The Lanterman Act (California Mental Retardation Services Act of 1969), Assembly Bill 225, 1969

House Resolution 372 of the 1968 Regular Session called for a study of California's mental retardation services for the reason that many areas in the State still had the problems which led to the creation of the regional centers in 1965 and, even in those areas served by regional centers, many problems still existed. The resolution proposed by Assemblyman Frank Lanterman in June 1968, was directed to the study of the use of facilities and programs in the care of the mentally retarded. It was resolved that the Assembly Rules Committee assign to the appropriate committee for interim study the subject of the delineation of the role and responsibility of the state hospitals and community programs ... including but not limited to a consideration of how the state hospitals can be most efficiently used, with the aim of establishing a framework in which a master plan for the use of these various resources might be developed.

The study resulted in the California Mental Retardation Services Act of 1969 which amended the heading of an article in the Health and Safety Code having to do with the guardianship and conservatorship of mentally retarded persons, repealed some of the sections of the Health and Safety Code which were added by AB 691 (Waldie), and added a major division to the Code assigning area responsibilities and expanding on the role of regional centers.

Article 7.5 of the Health and Safety Code was amended to state that AB 225 enacts the California Mental Retardation Services Act of 1969 to provide new procedures for the care and treatment of mentally retarded to take the place of existing commitment systems for such persons.

Division 25, Services for the Mentally Retarded, consisting of the following 7 chapters, was added:

Chapter 1. General Provisions - Mentally retarded persons shall no longer be judicially committed but shall receive services in accordance with this division. For purposes of the Lanterman-Petris-Short Act mental retardation shall constitute a form of mental disorder but shall not be considered gravely disabled under that act. This chapter states that mentally retarded persons shall not be released from state hospitals on leaves of absence except for short home visits but shall be discharged and referred to the regional center for services.

Chapter 2. Area Boards - This chapter directs the Secretary of the Human Relations Agency to divide the state into areas for the purpose of planning and coordination and authorizes the appointment of areawide mental retardation program boards for each area. The size, appointment authority, and terms of office of board members are specified. The chapter states that each area board shall adopt an areawide mental retardation plan providing for the most economical and appropriate use of all existing mental retardation agencies and existing personnel. Area plans, which may include individual county plans, shall be submitted to the Secretary of the Human Relations Agency for approval and transmission to the Areawide Comprehensive Health Planning Agency and the State Comprehensive Health Planning Council.

Chapter 3. Regional Centers for the Mentally Retarded - This chapter states the intent of the Act to establish a network of regional diagnostic, counseling, and service centers easily accessible to every family throughout the State. Private, non-profit community and local public agencies shall be utilized for the purpose of operating regional centers. After July 1, 1971, except for those mentally retarded persons placed in state hospitals pursuant to the Lanterman-Petris-Short Act, admissions to and discharges from state hospitals shall be through the regional centers. Regional centers are required to develop a plan for mental retardation services in the region. The total number of regional centers for the State are not specified.

Chapter 4. Guardianship and Conservatorship - This chapter states the intent that the Director of Public Health and not the Director of Mental Hygiene shall be appointed as guardian or conservator for the mentally retarded.

Chapter 5. State Mental Retardation Program Advisory Board - The chapter specifies the size, appointment authority and duties of the State Board. It further specifies that the Board shall advise the Health Planning Council, the Secretary, the Governor, and Legislature on the initiation, coordination, and implementation of programs and projects for the mentally retarded.

Chapter 6. Financial Provisions - This chapter states the intent that State funds previously allocated to other agencies for the provision of out-of-home hospital and post-hospital care be allocated to regional centers and provides authority to accept and expend federal funds. Parental contributions, for services to children under the age of 18, shall be made only to the regional center. Costs shall be based on ability to pay not to exceed the cost of caring for a normal child at home. This chapter repeats the statement made in AB 691 that there will be no charge for diagnostic and counseling services provided by regional centers. The parent fee-for-service schedule was to be submitted to the Legislature during the 1970 Regular Session. The chapter specifies that parent contributions shall be utilized for the provision of additional direct services for the retarded. County payments of $20 per month for each person are specified regardless of whether a state hospital or non-state facility is providing service. The amount is to be reduced by the amount of the parent contribution. Counties are not required to pay for services while the person is living at home.

Chapter 7. Evaluation - An evaluation of all aspects of the program are called for by January 1, 1973.

Services

In 1969-70 the estimated total cost of services to the mentally retarded in California was $210million of which $44 million, or 21%, were school funds; $18 million, or 8.6%, were federal funds; and $1.9 million, or 0.9%, were county funds. The balance was appropriated from the State general fund.

These expenditures represented an estimated caseload of approximately 14,000 retarded persons in the Department of Mental Hygiene; 4,400 in the Department of Social Welfare; 2,400 in the Department of Rehabilitation; 780 in regional centers; 58,000 in classes for the educable mentally retarded; 8,500 in classes for the trainable mentally retarded; and 1,000 in Developmental Centers for Handicapped Minors.

State Hospitals

California has a total of thirteen state hospitals of which four are exclusively for the mentally retarded. Five of the hospitals for the mentally ill have units for the mentally retarded. The remaining five are hospitals exclusively for the mentally ill.

The four state hospitals for the mentally retarded are: Fairview State Hospital, Costa Mesa, Orange County; Pacific State Hospital, Pomona, Los Angeles County; Porterville

State Hospital, Kern County; and Sonoma State Hospital, Eldridge, Sonoma County.

The state hospitals, administered by the Department of Mental Hygiene, serve assigned areas in the State. Fairview State Hospital, for example, serves San Diego, Imperial, and Orange Counties and one-third of Los Angeles County. Pacific State Hospital, on the eastern edge of Los Angeles County, serves Riverside and San Bernardino Counties, and two-thirds of Los Angeles County.

In August, 1970, 75% of all state hospital beds for the mentally retarded were located in Fairview, Pacific, Porterville, and Sonoma. The remaining 25% were located in the five state hospitals for the mentally ill. Of a total rated capacity for the State of 11,129 beds for the mentally retarded, 8,315 were located in the four state hospitals for the mentally retarded and 2,814 in the other state hospitals.

The total in-patient, mentally retarded population for all nine state hospitals was 11,483 at the beginning of fiscal year 1971. The four state hospitals for the mentally retarded had a total population of 9,266. Fairview had an in-patient population of 2,127; Pacific, 2,254; Porterville, 2,132; and Sonoma (the largest of the four) had 2,753. The remaining 2,217 mentally retarded persons were located in Agnews, Camarillo, DeWitt, Napa, and Patton State Hospitals. Of the five, Camarillo had the largest population of mentally retarded with 587; Napa, the fewest with 204.

On September 1, 1970, two months after the start of the fiscal year, the total in-patient population of all state hospitals decreased by 85 to 11,398. By the end of the fiscal year, the Department of Mental Hygiene was forecasting a 4.5% drop in state hospital population or a decrease of 524 in population bringing the total down to 10,959.. The forecasted decline, to be attained by normal attrition and community placements, reflected the policy of the Department to reduce the populations of all state hospitals to rated bed capacity.

Despite the forecasted reduction in size of the state hospitals, the Department of Mental Hygiene estimated that there would be 732 first admissions and re-admissions to the state hospitals in fiscal year 1971. Fairview, Pacific, Porterville, and Sonoma

State Hospitals will admit 575 new patients. Agnews, Camarillo, DeWitt, and Patton State Hospitals will be admitting 157 new patients.

By comparison, the nine state hospitals for the mentally ill have a 15,663 bed capacity compared to the 11,129 bed capacity fot the mentally retarded. The forecasted population in the hospitals for the mentally ill will drop from 12,671 to 11,900; however, where 732 admissions are estimated for the mentally retarded; 43,500 are estimated for the mentally ill.

In 1967-68, the Department of Mental Hygiene expended $58.4 million for the full range of in-hospital services in the four state hospitals for the mentally retarded and mental retardation units in five hospitals for the mentally ill. Total expenditures rose to $65.3 million for the same services in 1968-69.

Among the five states being studied, the State of California admitted the fewest patients and had the lowest number of resident patients in state hospitals for the mentally retarded for the size of the state. California's daily expenditure of $14.85 however, twice as high as that of Ohio, was highest among all five states.

Regional Centers

The regional centers of California, superficially resembling the Community Centered Program of Colorado, are proposed in the 1969 Lanterman Act as the network of regional diagnostic, counseling, and service centers for mentally retarded persons and their families, easily accessible to every family throughout the State. Authorized by the Legislature in 1965, regional center services to the mentally retarded were initiated in March 1966. In fiscal year 1966-67, the first full year of operation, total expenditures through two regional centers were $596,000. Four years later, in fiscal year 1970-71, nine regional centers in operational or organizational phases will expend an estimated $7 million in State funds.

The concept of establishing a single point of intake and referral for the mentally retarded in a community setting is also the basis upon which the Community Centered

Program in Colorado was established. However, where the problem that led to the regional center program in California was the waiting lists of the state hospitals, the problem in Colorado was probably tied closer to the lack of special classes for the trainable mentally retarded in local school districts. In Colorado, in 1970, there were 23 Community Centered Programs serving 34 of the 63 counties in the State. In California, in 1970, there were nine regional centers serving 44 of the 58 counties in the State. Colorado appropriations for fiscal year 1971 were $1.4 million; however, the state-local share formula being 75%-25%, the gross worth of the Community Centered Programs will be close to $1.9 million. The 25% of local share can be contributed in cash or services-in-kind. A major portion of the local cash contribution is provided by local school districts.

The first two regional centers, authorized in 1965, were the Golden Gate Regional Center serving persons in five counties in the San Francisco area and the Children's Hospital Regional Center serving persons in the Los Angeles area. The regional network, currently authorized at nine Regional Centers, leaves four planning areas not covered by center services.

By the end of 1968, the San Diego Regional Center at the Children's Hospital and Health Center began operation (San Diego and Imperial Counties). The three authorized in 1969 were the Loma Prieta Regional Center (serving Santa Clara, San Benito, Monterey, and Santa Cruz Counties), the Alta California Regional Center (thirteen counties in the Sacramento area), and the Central Valley Regional Center at Fresno (Merced, Mariposa, Madera, Fresno, King, and Tulare Counties). The last three to be authorized were the Far Northern Regional Center (serving nine counties in the northeast corner of the State), the Tri-Counties Regional Center (Santa Barbara, San Luis Obispo, and Ventura Counties), and the Children's Hospital of Orange County Regional Center (serving Orange County; one of the two regional centers serving one county, the other being Children's Hospital of Los Angeles).

The fourteen counties not being served by regional centers include four counties in Area I in the northwest corner of the State; three in Area IV, directly north of San Francisco; two out of five counties in Area VI, lying in the Great Valley due east of San Francisco; Kern County, one of the seven counties in Area VII; and all four counties of Area XII (Mono, Inyo, San Bernardino, and Riverside).

During the first two years of operation, the Golden Gate and the Children's Hospital of Los Angeles Regional Centers' active caseload increased from 471 persons, which included 2,505 case-months of purchased services, for a total expenditure of $596,000 to a caseload of 589 persons in the following year, which included 4,248 case-months of purchased services, for a total expenditure of $1,029,000. The $1.2 million budget of the Golden Gate Regional Center in fiscal year 1971 exceeded the total cost of both centers in fiscal year 1968. The average cost per month of service in 1966-67 was $238. It rose to $242 per month in 1967-68.

The regional centers, as contractors to the State Department of Public Health, are tied to the community primarily through the sponsoring local agency; e.g., the local children's hospital or the retarded children's association. Other than this link, the regional centers are primarily dependent organizational units of the State agency. Vendors of services which the regional centers can purchase, for example, are specified by the State agency and used, in accordance with State definition, by the regional centers.

Special Education

The programs of special education of the California Department of Education include special classes and home or hospital instruction for the educationally handicapped, mandated special classes for the educable and trainable mentally retarded, pre-school classes for 3-5 year olds, Developmental Centers for Handicapped Minors for multi-handicapped children, and transportation for TMR and physically handicapped pupils.

In 1969, there were 9,222 trainable mentally retarded children enrolled in special day classes compared to 7,670 enrollees in 1967. In 1969, there were 59,386 pupils enrolled in educable mentally retarded classes compared to a total of 55,868 two years prior. Total State expenditures during the school year 1968-69 were $7.8 million for the TMR classes and $33 million for the EMR classes. State reimbursement for educable mentally retarded classes was $435 ADA or $7,820 per class and $795 ADA or $9,540 per class for trainable mentally retarded classes.

The minimum mandatory age is eight years with a maximum of eighteen years. Programs for children down to the age of five or for youth up to the age of 21 may be provided at the discretion of the local school district or the county superintendent of schools.

In 1965, the California Legislature appropriated funds to establish Developmental Centers for Handicapped Minors. In 1968-69 there were 29 centers operating in the State under the auspices of the local superintendent of schools and the Department of Education. These centers are designed to serve handicapped youngsters between the ages of three and 21 who are ineligible for other community services but for whom state hospital placement is not required. In 1967-68, the State appropriation for the Developmental Centers for Handicapped Minors was $2.5 million. It increased to $3.1 million in 1968-69. The 1968 center population was approximately 1,020 children and youth.

The special transportation fund for trainable mentally retarded persons was $3 million in 1967-68. It rose to $3.2 million in 1968-69.

A current issue concerning special education in California is the challenge of minority groups on the validity of various educational tests to determine placement of children in special education classes. Studies in school districts have confirmed the fact that a disproportionate number of minority group children have been placed in classes for the retarded. The problem has been recognized by resolution in the Legislature and testing has been significantly altered and limited.

Community Placement

In 1969, the Community Services Division of the Department of Social Welfare provided supervised community living opportunities to approximately 6,300 mentally retarded persons. These are the persons requiring post-hospital care or the persons who are at risk of requiring state hospital care. The Division's family care program accommodated approximately 2,675 of these individuals. Approximately 2,300 were placed in community living situations.

For three fiscal years starting in 1970, the Community Services Division at the request of the Department of Mental Hygiene, projected an annual 1,400 retarded person caseload increase in order to help reduce state hospital populations.

The Division's total appropriation in 1967-68 for both the mentally ill and mentally retarded was $12 million. This amount included programs for the placement of the mentally ill and mentally retarded in community living situations, in-patient services to hospitalized individuals, pre-admission services, and pre-release services for those in residence but about to be released from the state hospitals.

Rehabilitation

The Department of Rehabilitation cooperated with other State and local agencies in the establishment of programs for the mentally retarded in 28 school districts, a program at DeWitt State Hospital, and a residential rehabilitation center at Agnews State Hospital. The total caseload of mentally retarded persons served by the Department of Rehabilitation in 1969 was 4,029. The number of mentally retarded persons placed in jobs in 1969 was 1,209.

The cooperative school programs were aimed at practical work experiences as part of the school curriculum. There were 1,214 new admissions to the school program in 1969 and a job placement total of 496.

In 1969, the Department awarded $540,000 in eleven grants to cover the costs of planning, remodeling, equipping, or expanding workshops throughout the State.

In 1967-68, the total estimated expenditure by the Department on cooperative programs with local school districts, under contract with regional centers, in state hospitals and residential centers was $2.4 million. This amount increased to $2.7 million in the year following.

Youth Authority

In 1968 the Department of Youth Authority began a programto identify the mentally retarded in its delinquent population. The estimate for that year of the Department's intake of the retarded was 10% to 25% of the total delinquent population. At that time, the Department was still in the process of clarifying the role that they should assume on this problem.

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2. COLORADO

General Characteristics of the State

Area, Population and Income

A land area of 103,794 square miles places Colorado eighth in size among all states and second to California among the five states being studied. Colorado covers an area two-thirds the size of California and is one and one-half times larger than Washington.

Colorado is one of the states of the plains and Rocky Mountains. Slightly rectilinear in shape, with its greatest dimension along the east-west axis, its topography consists of three distinct landscapes. The eastern third is the plains region. The Rockies occupy the central third. The western third, popularly known as the western slope, is a region of broken ranges, plateaus, and valleys.

Topographically Colorado is similar to the Pacific coastal states of California and Washington with their low coastal areas, inland mountains, and eastern plateaus and valleys. Colorado, however, unlike Washington, does not have one major population center in the section of the state beyond the dividing mountain range.

In 1970 Colorado had a population of 2,207,259 placing it 30th in rank among all states. Its size and population make it the most sparsely populated state of the five states being studied. Washington, next in population, has half again the number of residents but has more than twice the population per square mile as does Colorado. Colorado, 8th in physical size among all states, 30th in terms of population, is 40th in population density with 19 persons per square mile of land.

The Rocky Mountains, central third of the state, contribute heavily to Colorado's low population density. The region of the western slopes is also lightly populated with much of this region being devoted to agriculture and grazing. In the eastern third, the most populated area is around Denver. The population drops sharply along the northern and southern borders and in the plains area toward Kansas and Nebraska.

In 1967 there were three Standard Metropolitan Statistical Areas in Colorado. The metropolitan areas and their component counties were Colorado Springs SMSA (El Paso County), Denver SMSA (City and County of Denver, Adams, Arapahoe, Boulder, and Jefferson Counties), and Pueblo SMSA (Pueblo County).

The largest of these was the Denver SMSA lying on the eastern slope of the Rockies, slightly north of the mid point of the state. The Colorado Springs SMSA lies to the south of Denver and the Pueblo SMSA lies due south of Colorado Springs. The Denver SMSA houses more than one-half of the State's 2 million residents while the 3,665 square miles covered by the metropolitan area represents only 3.5% of the State's total acreage. Both the Colorado Springs and Pueblo metropolitan areas are classified as SMSA's with populations under 250,000.

The Denver SMSA consists of the City and County of Denver, and Adams, Arapahoe, Boulder, and Jefferson Counties. Boulder County, located northeast of Denver, is the least populated of the five. Even as the smallest of the Denver SMSA group, Boulder County is equalled or exceeded in size by only three other counties in the State - Weld, El Paso, and Pueblo. Weld lies directly to the north of Denver on the border below Wyoming and Nebraska. El Paso lies two counties south of Denver. Pueblo is located south of El Paso County. The Denver SMSA and these three counties, all located in a north-south line along the eastern slope of the Rockies, account for more than 70% of the total State population.

The problems presented by the uneven distribution of the resident population of the State are compounded by the migration of both out-of-state and in-state seasonal farm workers. The four areas of migrant concentration, according to the Colorado Migrant Council, are located in northern Colorado, the Arkansas Valley, the western slope of the Rockies, and the San Luis Valley on the southern border of the State. These "pockets" are in sparsely settled areas. In this regard, Colorado shares a problem peculiar only to one other state among the five being studied. The migrants in California seasonally rotate through the vineyards, orchards, and farmlands of that state. Low county populations in Colorado possibly result in a higher migrant-to-resident population in Colorado than in California.

The San Luis Valley lies near the southern border of the State in the central Rockies region. In a survey conducted by the Division of Rehabilitation, the Conejos, Costilla, Alamosa, Rio Grande, Mineral, and Saguache Counties region contains the highest number of low income families and is the region with the greatest lack of services for the handicapped. The six counties in the southeastern corner of the State are classified as second most impoverished and needy of services.

Colorado residents' gross personal income in 1967 was $6.2 billion. Per capita personal income for that year was $3,135; slightly below the national average. In terms of national rank, the $6.2 billion gross placed Colorado in 28th place. The State rose to 20th place in terms of per capita personal income.

Local Governments and Districts

In 1967 Colorado had a total of 1,252 local governments of which 63 are counties, 251 municipalities, and 191 school districts. The latter included junior colleges. There are no townships in the State of Colorado.

The 63 counties of Colorado have an average population of 35,000. The greatest number (26) have populations less than 5,000. Only Denver County has a population near 500,000. By comparison, North Carolina has an average county population of 51,000; Washington, 87,000; Ohio, 121,000; and California, 340,000. California, the only state being studied larger in area than Colorado, has 58 counties.

The 191 public school districts managed a total of [illegible] public schools in 1967 with a total enrollment of 505,000 students. The majority of these public school systems have local taxation rights. Special education for the mildly retarded is an option of the local school district.

The number of school districts per county ranges from one to seventeen. Denver, with a population of approximately 500,000, has one school district. El Paso, with a population of approximately 150,000, has seventeen. Fifty-six school districts have territories extending into two counties and a few have territories extending into three or more counties. Of the 191 school districts, only 14 have territories coterminus with county or city boundaries. The balance (177) have non-coterminus boundaries. Approximately one-third of all school districts operate one school only.

There is only one consolidated city-county government in the State of Colorado. Denver is both a city and a county. Denver and the four counties surrounding it constitute the Denver metropolitan area housing half of all the inhabitants of the State. By comparison, the Rocky Mountain counties of Mineral, San Juan, Gilpin, and Hinsdale have populations numbering in the hundreds. Even among the more populated 26 eastern plains counties, the region in which Denver is located, there are very sparsely settled areas. Sedgwick, lying in the extreme northeast, Nebraska bordered, corner of the State, and Crowley, lying due east of Pueblo County in the southern third of the State, have populations under 5,000.

Revenue and Expenditures

In 1967, general revenues of the State of Colorado amounted to $1.2 billion placing it 28th in revenue rank among all states. Total expenditures for that year ran $18 million lower than total revenue. Approximately $1 billion in revenue were obtained from within the State; the balance of $200 million from the federal government. Taxes, including individual income, accounted for $677 million of the $1 billion received from sources within the State.

Colorado follows California and Washington in terms of per capita State general revenue and expenditures. In 1968 Colorado state and local expenditures per person ran 80% of the $684 annual per capita expense of the State of California. However, Colorado's expenditures were 1.5 times greater than North Carolina's $366 per capita expenditure, the lowest ranking of the five. Washington and Colorado led all five states in educational expenditures per person for that year.

The Fiscal Year 1971 appropriations bill of the Colorado Forty-seventh General Assembly established a general operating budget of $497 million and a capital construction fund of $41 million for a total of $538 million for the year.

Selected entries in the appropriations bill of interest to the field of mental retardation are as follows:

Department of Education	$ 143,156,000
For distribution to local districts	
Migrant education	170,000
Education of the handicapped	5,750,000
Department of Institutions	
Division of Mental Retardation	10,858,000
MR Centers	1,624,000
Ridge Home & Training School	5,546,000
Grand Junction Home & Training Sch.	3,564,000
Division of Mental Health	
State Hospital, Pueblo Mental Retardation Services	3,531,000
Community MH Clinics	1,240,000
Department of Social Services	
Division of Public Welfare	49,406,000
Aid to Dependent Children	9,004,000
Aid to Needy Disabled	2,111,000
Child Welfare	4,298,000
MR Placement Program	347,000
Division of Rehabilitation	1,215,000
Department of Health	
Rubella vaccine for children in kindergarten through grade 6	228,475

The $5,750,000 for the education of the handicapped represents a $750,000 increase over the budget for the preceding year. Part of these funds will be used for the educable mentally retarded, specifically for the excess costs of special education. The Colorado Association for Retarded Children estimates that this amount will be sufficient only for 62% of submitted claims.

The $347,000 received by the Department of Social Services for the placement of institutionalized mentally retarded individuals in community facilities represents an increase of $97,000 over the year 1969-70. The placement program is jointly administered by the Department of Social Services and the Department of Institutions.

Included in the appropriation to the Division of Mental Retardation was $1,434,000 for community centered programs and an additional $265,000 for community center boards for day-time activity programs. The appropriations for the preceding year were $1,333,000 and $65,000.

State Organization

Five departments in the State government of Colorado are directly concerned with problems of the mentally retarded: (1) Department of Institutions; (2) Department of Social Services; (3) Department of Education; (4) Department of Health; and (5) the Department of Vocational Rehabilitation. Categorical assignments to the specific problems of the mentally retarded, within those departments, are made to the Division of Mental Retardation (Marvin Meyers, Chief) in the Department of Institutions and to the Division for Special Education Services (Dr. John Ogden, Director) in the Department of Education.

There are two advisory committees on mental retardation in the State government organization. One, temporarily discontinued in the summer of 1970, is the Governor's Committee on Mental Retardation and Mental Health; the other, whose nine members are appointed by the governor, functions as advisor on the State's community centered programs. Membership in the latter consists of representatives from the departments primarily concerned with problems of the mentally retarded and consumer and community representatives.

The Department of Institutions, the director (Judge Hilbert Schauer) of which is appointed by the governor under an authorization outside of the civil service, has assigned the responsibility for the State's three institutions and the community centered program to the Division of Mental Retardation. Two of the institutions, the State Home and Training Schools at Ridge and Grand Junction, are dedicated solely to the mentally retarded. The third institution operates on the grounds of the Colorado State (Mental Health) Hospital at Pueblo.

Two departments with directors appointed in accordance with the regulations of the classified civil service are the Department of Social Service and the Department of Health. The principal MR program of the Department of Social Service is the placement program for individuals moving from the State institutions to community living situations. This department is also responsible for the licensing of foster homes and the community centered facilities. The Department of Health, responsible for programs such as the rubella vaccine program, licenses extended care facilities, nursing homes, and residential facilities in the State. The Health Facilities Advisory Council of the Department recommends facilities for construction grants. The well-baby clinics, maternal and child health services, crippled children services, and visiting nurse services of local departments of health are administered by the State Department of Health.

Planning and Planning Coordination

The first statewide comprehensive plan for the mentally retarded in Colorado was published in June 1965 under the title, "These Truths are Evident." In December 1968, a second state plan titled, "Looking Ahead: A New Program Plan for the Mentally Retarded" was published by the Division of Mental Retardation, Department of Institutions with funds provided by the 1967-68 Colorado State Legislature.

Sometime after the first statewide plan was published and before the second plan was started, the Division of Rehabilitation of the Department of Social Services prepared a statewide plan for rehabilitation under the authority of legislation enacted by the 89th U. S. Congress. The Division received a grant from the Rehabilitation Services Administration, Social and Rehabilitation Service of the Department of Health, Education, and Welfare to plan services for the disabled so that those who would have need and could benefit from such services could have them by 1975. The plan was developed under the jurisdiction of an appointed 40-member Statewide Advisory Committee.

The 1965 plan for the mentally retarded developed recommendations based on service needs in eleven regions. These same regions were later used by the Division of Rehabilitation for their statewide plan. The counties on the western slopes of the Rockies were divided into two planning regions, the Rocky Mountain counties into three planning regions, and all the eastern slope and plains counties into six regions. Region 11 included the city and county of Denver and nine adjoining counties. In the plan of the Division of Rehabilitation, Region 11 was further divided into four subregions.

Primarily as a result of the 1965 planning and implementation program community centered programs were initiated in various locations throughout the State. The needs of the trainable mentally retarded and seriously handicapped held priority in these programs. The 1968 plan stressed the need for home types of environments; i.e., foster and group homes, for the institutionalized resident capable of living in the community.

The plan of the Division of Rehabilitation included mental retardation as one of seventeen disabilities ranging from deformities, amputations, blindness, deafness, asthma, cerebral palsy, alcoholism, and emotional disorders. In their planning report, which was developed through questionnaire and hearings, the Division expressed surprise that there were not more recommendations of service for the mentally retarded. They reasoned that many of the recommendations for the mentally retarded were included in the recommendations for special education, sheltered workshops, and the like. Of the two recommendations for the mentally retarded one was aimed at the lack of power of community centered boards to raise money in the community. In the State of Washington where this authority exists, the problem of the county boards is the lack of state funds to supplement the income raised from communities.

The 1968 report, strongly stressing the potential of the community centered program, included estimates of major declines in institutional populations if community centers were funded. Starting with an institutional population of 2,480 and a community center population of 1,070 in 1968-69, the report claimed that the total institutional population could be reduced to 930 by 1975-76 if the community center population was raised to 3,154 and community residential care raised to 1,760. These estimates are not cited in the current plans of the Division of Mental Retardation.

The eleven regions established during the P. L. 88-156 planning period are not visible in the current plans of the Division; e.g., there are no regional authorizations nor regional appointments.

In September 1970, the State Planning Office issued a directive to all departments in which twelve planning regions were established. The memorandum stated that the Office was complying with a U.S. Bureau of the Budget requirement calling for the establishment of regional territories and clearinghouses. Only two of the planning regions coincided with the eleven comprehensive planning regions for mental retardation and mental health.

Legislation

Legislative enactments in the State of Colorado, introduced as House or Senate bills, appear in the form of Colorado Revised Codes or Statutes. Some of the Codes governing the programs of State agencies are the reorganization of the Department of Institutions (Chapter 3: Article 11), the Colorado Children's Code (22:1), the Child Care Act (119:8), Aid to Dependent Children (119:9:1), and the organization of the Department of Education (123:1:22). Selected chapters of the Code or bills related to programs for the mentally retarded are cited below:

Chapter 123, Article 22 - Handicapped Children Educational Act

This chapter specifies the means whereby the children in the State of Colorado who are physically, mentally, educationally, or speech handicapped will be educated.

The section on the educable handicapped establishes limits of responsibility starting at 5 years of age and extending to 21. Responsibility for other handicapped children may start at the age of 3. The code says that any school district may establish a special program for the education of the handicapped child and that the State will reimburse the school district for part of the costs of the program. Reimbursement formulae specify payments of 80% of the compensation of approved personnel, 50% of the cost of transportation, and up to $800 per school year for the cost of maintenance of a child in a foster home.

Chapter 71, Article 8 - Community Centers for the Mentally Retarded and Seriously Handicapped

This chapter establishes a community centered program through interagency cooperation and coordination of the local agencies that offer services to the mentally retarded and seriously handicapped and establishes a program to purchase services through community incorporated boards. These may include services available from public or private non-profit sheltered workshops, day care training centers, and other private facilities. In case facilities are not available in a community, the community incorporated board may develop and operate such facilities directly. Payments for services by the Department of Institutions shall not exceed 75% of the annual cost of the approved community centered programs. Community matching funds may consist of cash or services in kind. Section 4 of Article 8 specifies that a State Coordinating Advisory Board shall be established to advise and consult with the Director of the Department of Institutions on this program.

Some of the bills relating to mental retardation were introduced into the Colorado Legislature as a result of the planning program authorized under P. L. 88-156. Three of these are listed below:

H. B. 1221. May 1965

This bill authorized the State Department of Public Health to license annually and to establish and enforce standards for the operation and maintenance of facilities for the mentally retarded and other hospitals.

H. B. 1007. June 1965

Every newborn infant should be tested for phenylketonuria and other metabolic defects in order to prevent mental retardation resulting therefrom and the people of the State should be extensively informed as to the nature of such defects.

H. B. 1426. April 1967

Relating to abortion - (if) continuation of the pregnancy in their (accredited hospital) opinion is likely to result in: the death of the woman; or the serious permanent impairment of the physical health of the woman; or the serious permanent impairment of the physical health of the woman as confirmed in writing under the signature of a licensed doctor of medicine specializing in psychiatry; or the birth of a child with grave and permanent physical defomity or mental retardation....

The 1970 legislative platform of the CARC provides some insight into the problems that have developed as a result of the special education and community centered programs of the State. The object in citing the CARC recommendations is to point out the fact that the legislative concerns in Colorado, although differing in detail, are typical of the other states in that new problems often become more apparent as various solutions are tried.

With regard to special education, the CARC maintains that many school districts are shirking their responsibility for the education of the mentally retarded child and that permissive policies of education are denying children of their right to schooling. The trainable mentally retarded, according to the CARC, are almost entirely excluded from the public school system. The legislative remedy suggested by the CARC consists of the following:

> Legislation requiring school district to provide programs of education for the educable mentally retarded.
>
> Legislation requiring the school district to provide or purchase education for the trainable mentally and, if purchased, up to an amount at least equal to the amount of local tax money spent on the education of a student in the regular school program.
>
> Legislation requiring school districts to begin services for the mentally retarded at an age no later than that at which training is provided for other handicapped children.
>
> Appropriation of state funds to enable school districts to meet the excess costs of special education.

The second most important area of concern of the CARC lies in the area of the community placement of the mentally retarded. The problems cited by the CARC range from the rate of development of community facilities to the guardianship of individuals assigned to these facilities. Legislative remedies include the following:

> Legislation providing for guardianship and protective services in community facilities such as is already provided to the institutionalized individual.
>
> Legislation establishing state support up to 90% of program costs in impoverished areas and providing for minimum state support of 75% in other areas.

Various appropriations so that the capability of State institutions can be maintained and so that community centered programs can develop more effectively. Included in this recommendation is the appropriation of funds to the Department of Social Services for the Division of Rehabilitation so that sheltered workshop or supervised daytime activity programs can be developed in community centered programs.

With regard to the problems of the community centered programs, the State of Colorado is experiencing a problem common to all the other states being studied. All states are moving toward community placement and the reduction in size of institutions. Implementing such a plan requires the build-up of community facilities first and then the gradual transfer of institutional residents to these facilities. In practice, both are occurring at the same time. The net effect is a solution of the institutional problem at a cost to the community. There are signs that Colorado is beginning to realize that the community centered programs might not have a major effect on the State institutions and that both types of facilities might have to be developed. In the State of Washington the same sign appears in the form of a recommendation by the Division of Handicapped Children for regional (institutional) centers in addition to the five major institutions despite the build-up of day care centers and group homes.

Service

State Home and Training Schools

The three state institutions at Ridge, Grand Junction, and Pueblo have a total population of approximately 2,200 residents. The full-time professional staff of all three institutions is 141 of which two are psychiatrists, six are physicians, ten psychologists, 12 social workers, 42 nurses, 30 teachers, 29 special therapists, and ten administrators. The 1970 appropriation for Ridge was $5.6 million (compared to $5.1 for the previous year); $3.6 million for Grand Junction (compared to a previous $3.3 million); and $3.5 million for the Mental Retardation Center in Pueblo.

Funds for the Pueblo Center were appropriated to the Division of Mental Health of the Department of Institutions despite the fact that the Center has been transferred by executive order to the Division of Mental Retardation. Jurisdictional problems have arisen on this subject because the Mental Retardation Center continues to be administered by the Colorado State Hospital in Pueblo and yet is considered to be part of the Division of Mental Retardation.

The formal transfer of the Mental Retardation Center to the Division of Mental Retardation will give sanction to the Center as the third residential institution in the State; thereby paving the way for a regional assignment of responsibility for the institutionalized retarded individual. Under the present arrangement the Mental Retardation Center is informally assigned the southeast quadrant of the State; Ridge accepts the northeast quadrant as its primary area of responsibility; and Grand Junction assumes jurisdiction over the western third of the State.

Among the five states being studied, Colorado was one of the two states showing a significant decline in institutional population during the fiscal year 1969. Both Colorado and California showed decreases of approximately 8% while Ohio and Washington remained comparatively stable. The institutional population in North Carolina increased during that period.

Diagnostic Centers

The State of Colorado, like Washington, does not maintain a formal network of diagnostic centers throughout the State. The fourteen centers that do provide diagnostic and evaluation services are public and private organizations such as the State Home and Training Schools, the University of Colorado, Children's Hospital in Denver, and Goodwill. According to a 1968 estimate of the diagnostic and evaluation capability within the State, five of the eleven mental retardation planning regions have clinics that can provide such service. Six regions, representing 29 counties, do not have such services.

Community Centered Programs

Colorado's community centered program, administered through the Community Services Section of the Division of Mental Retardation, Department of Institutions, was established by the General Assembly in 1964. In 1970 there were 23 community centered programs being administered by local incorporated boards. The appropriation for 1970-71 was $1,433,900 on the basis of 1,886 individuals being served at an average rate of $760 ADA.

In 1964, with a registration of 600, the appropriation was $200,000; 1965-66, $300,000; 1966-67, $500,000; 1967-68, $700,000; 1968-69, $981,150; and 1969-70, $1,333,382.

These funds are made available to the local boards to be used for the purchase of training services not already the responsibility of other agencies. In the absence of available service, the board may elect to develop and provide the service itself. State funds are matched by funds or services in kind from the community. The State may pay 75% of the annual cost of the programs; the community pays the balance. At least half of the community matching money must be in cash. The other half may consist of services. Originally, the matching formula was 50:50.

In 1970 the community centered boards and their satellite programs accounted for activity in 34 of Colorado's 63 counties. The counties without community centered programs were the cluster of northwest counties and the counties lying east and south of the Denver area.

According to the administrators of the program in the Division of Mental Retardation, each program acts as a central point of referral for the mentally retarded in the area of that program. The centers are responsible for interagency program planning and arranging for services through casefinding, intake, evaluation, consultation and referral. The types of services offered directly by the program or through purchase agreements with suppliers include pre-school, day training, vocational rehabilitation, and work activities.

Problems being encountered by the community centered program include how payments should be made to individuals so that equity is maintained, how the State can meet its obligation of paying for 75% of costs while still not exceeding the $760 payment per person, and how the problems of jurisdiction between the Department of Institutions and the Department of Social Services can be solved without denying an individual service.

Placement Services

The Department of Social Services receives a special appropriation for the placement of mentally retarded individuals in community facilities and programs. In March 1970, approximately 265 children and adults had been placed in community situations by the Department. Working with an appropriation of $250,000 the Department's goal for the year was 381 placements.

Of the 165 adults placed in the community through March, 54 had been placed in nursing homes, 39 in intermediate health facilities, 29 in residental facilities, 32 were given room and board, and eleven were placed in their own home or with relatives. Child placements were made in the child's own home, foster homes, and private residential institutions.

Special Education

At the beginning of the 1969-70 school year, the Colorado public school system was serving 6,214 educable mentally retarded children in 46 school districts and nine cooperatives. These were the school districts that elected to establish programs for handicapped children. The total teaching staff consisted of 313 elementary teachers, 119 junior high teachers, and 91 high school teachers.

In 1965-66 the State appropriation was $1.9 million, less than half of the 1970-71 appropriation of $5.8 million. In 1968-69 the appropriation was $4 million.

Actual claims for reimbursement by school districts have been estimated to run between 20% to 35% higher than the amount appropriated. Part of the difference between actual costs and reimbursements lies in the limit of reimbursement of 80% of salaries and varying percentages of other costs authorized under the Handicapped Children Educational Act of the State of Colorado. There have been claims that the State is not reimbursing the districts up to the authorized level of matching; however, verifying the claim would require a detailed financial audit because of the different formulae used to determine reimbursement.

Mandatory vs. permissive special education is a constant subject of discussion in the State. Attempts were made to invoke mandatory special education in the past. These attempts failed in legislation. This subject is one of the primary legislative concerns of the Colorado Association for Retarded Children. The problem of mandate is complicated by the fact that there are a large number of widely dispersed school districts in the State with small school populations. Many of these districts and the counties in which they are located are financially unable to mount programs and many, if such programs are initiated, would be unable to staff them adequately. In essence, the topography, population distribution, and economic status of the State have strong effects on the problem of special education.

Work Experience-and-Study Programs

In 1970 there were 37 work experience-and-study programs in the State. These programs were initiated by the Division of Special Education Services of the Department of Education, the Division of Rehabilitation of the Department of Social Services, and the Division of Program Services of the State Board for Community Colleges and Occupational Education. The object of the program is to provide three years of work experience-and-study for high school youth who are aurally, educationally, physically, or visually handicapped or educably mentally retarded.

Under an agreement signed by the three sponsoring organizations, the Department of Education agreed to reimburse the school district for 80% of teaching salaries, 50% of transportation costs, and the full amount of maintenance, up to $800 per year, for a child in a foster home. Responsibilities and financial assignments were also agreed to by the other sponsoring organizations.

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3. OHIO

General Characteristics of the State

Area, Population, and Income

In 1970, Ohio's population was 10,652,000, up 9.7% since 1960. It was one of the 30 states that failed to grow as fast as the national average of 13.4%. In 1960, Ohio ranked fifth nationally in size. It was passed by Texas during the 60's and was ranked sixth in 1970. North Carolina, with a population increase of 11.5%, was the only other state among the five being studied that fell below the national average.

In terms of physical size, Ohio ranks 35th among all states with a land area coverage of 41,018 square miles. Smallest in size among the five states being studied, Ohio, with almost 260 persons per square land mile, is the most densely populated. It has more than twice the population density of California and more than thirteen times the number of persons per square mile than Colorado. North Carolina, the next larger state among the five, covers 20% more land area than Ohio (48,880 square miles) but has one-half the population (5,082,000).

Ohio has the topographic distinction of being the only state among the five without any distinctive geological features. Although the State is marked by Lake Erie to the north and the Ohio River along its entire southern border, its general surface is a rolling plain. The maximum variation from the lowest to the highest point in the State is 1,983 feet.

Three-fourths of Ohio's surface is glaciated. The glacial line extends from the mid-point of the State on its eastern boundary, heads due west, and then southwesterly toward the southern border. The area to the southeast of this line lies in the region of the Allegheny plateau. The Lake plains region in the northern part of the State and the central plains to the west are the agricultural areas of the State and account for the State's high (67%) commitment to farmland.

In 1967, there were sixteen Standard Metropolitan Statistical Areas located in Ohio or in areas which included some Ohio territory. Eleven were located wholly within the State. Five of the metropolitan areas were shared with Kentucky and West Virginia on the State's southern (Ohio River) border, Indiana on the western border, and Michigan on the northwest border. No metropolitan areas are shared with Pennsylvania on the eastern border of the State.

The Cinncinnati metropolitan area lies at the junction of Ohio, Kentucky, and Indiana in the southwestern corner of the State. It embraces seven counties; three of which lie in Ohio, three in Kentucky and one in Indiana. The Huntington, West Virginia-Ashland, Kentucky metropolitan area straddles the Ohio River on the southern border at the three state junction of Ohio, Kentucky and West Virginia. It is a four-county metropolitan area; two counties lie in West Virginia and one each in Ohio and Kentucky. The Steubenville, O.-Weirton, W. Va. metropolitan area lies on the eastern border and embraces one county in Ohio and two in West Virginia. The Toledo metropolitan area includes Lucas and Wood Counties in Ohio and Monroe County in Michigan. The Wheeling, W. Va. metropolitan area, the fifth of the shared SMSA's, lies on the eastern border south of Steubenville. It embraces Belmont County in Ohio and two counties in West Virginia.

In 1968, seven of the Ohio Standard Metropolitan Statistical Areas had populations in excess of 250,000. The Cleveland metropolitan area on the shore of Lake Erie was the largest with a population in excess of 2 million. In order of size, the others were Cinncinnati (1.8 million); Columbus (897,000); Dayton (843,000); Toledo (571,000 for Ohio counties); Akron (688,000) and Youngstown-Warren (552,000). The Cleveland SMSA ranked 11th among all metropolitan areas in the United States in 1968. Cinncinnati ranked 17th. By comparison, California, with twice the population, had 14 Standard Metropolitan Statistical Areas in 1968. North Carolina had seven; Washington, four; and Colorado, three.

In 1967, the gross personal income of the residents of Ohio was $33.6 billion; placing the state fifth in national rank. The per capita personal income of $3,213 for that year dropped the state to sixteenth place nationally but was high enough to keep the income of residents above the national average.

Although more than two-thirds of the land area in the state is committed to farmland, farm income of the civilian labor force accounted for less than one percent of the gross personal income of all residents. Manufacturing of all types accounted for more than 40% of the total income.

Local Governments and Districts

In 1967, there were 3,283 units of local government in the State of Ohio. Among these were 88 counties; 933 municipalities; 1,324 townships, and 713 public school systems. Ohio had 31 local governments per 100,000 inhabitants compared to the national average of 41.4 local governments per 100,000 inhabitants.

California, by comparison, with a population of 20 million, had 3,864 local governments. Ohio, with a population of 10.6 million, was second in the number of local governments in the state. Washington (1,652 local governments) ran third. Colorado with 1,252 was fourth. North Carolina, with 752 local governments, had the fewest.

Ohio and Washington were the only two states among the five with township forms of local government. In the case of Washington, formal townships existed in only two counties. In Ohio, every one of the 88 counties have some form of township government.

The Ohio counties are uniform in size to the extent that county boundaries appear to form an irregular grid superimposed over natural topographic features. All counties average 465 square miles in size. The largest are Ashtabula (706 square miles) in the far northeast corner of the State on the shore of Lake Erie and Ross (687 square miles) in the south central section of the State. The smallest counties are Erie (264 square miles) and Ottawa (263 square miles) on either side of Sandusky Bay, one of the State's two natural harbors on Lake Erie.

All counties have populations in excess of 10,000. The largest, Cuyahoga, the county in which Cleveland is located, has a population in excess of 1.7 million inhabitants. Most of the townships, on the other hand, have populations below 10,000. In 1967, only 101 townships, or 8% of all townships in the State, had more than 10,000 inhabitants.

By 1968, the number of school systems had dropped to 648 from the previous year's 713. In the period between 1951 and 1968 there was a negative 54% change in school districting compared to a national average of 71% for that same period of time. Among the five states, Ohio's consolidation of school districts was second only to Colorado which ranked among the top five states in reducing the number of school systems in the state.

Revenue and Expenditures

In 1968, the total revenue of Ohio was $3.2 billion; up approximately 12% from the 1967 amount. This increase was less than the national increase of 13.6%. Total expenditures for that year were $2.9 billion.

General revenue for 1968 came to a total of $2.3 billion. Sixty percent of this amount was obtained from sales and license taxes; the balance from intergovernmental and miscellaneous general revenues. There was no revenue from individual or corporate incomes.

Among the five states, Ohio and Washington are the only two without any state levies on income. In California, taxes on individual and corporate incomes accounted for 20% of all state general revenues. Individual and corporate income taxes in Colorado amounted to 18% of all general revenues. North Carolina's dependence on these taxes was highest with 23%.

The total revenue of local governments in Ohio was higher than the total State revenue. California was the only other state in which local governments collected more than half of all revenues collected by both the state and local governments. Local governments in Ohio received almost half of all general revenues from real estate and property taxes. Of all such taxes collected in the State, 96% are retained by the local governments and only 4% turned over to the State government.

Many local governments in Ohio, unlike the local governments in Washington, levy taxes on individual incomes. In 1968, 144 cities and 60 villages levied such a tax and the combined revenue exceeded $163 million. These local taxes on income amounted to more than 10% of the total local tax revenue.

General State expenditures accounted for $2.3 billion out of the total expenditures of $2.9 billion. The State's major expense ($881 million) was in the field of education. These expenditures accounted for almost 39% of all general outlay. Public welfare expenditures were $300 million, or 13% of total general expenditures. Public health expenditures amounted to $21 million or 9% of the total.

A comparison of the total general expenditures of Ohio with those of the other four states being studied emphasizes the lack of financial strength at the State level in Ohio. California, for example, with a population less than twice that of Ohio had general expenditures of $7.6 billion, three times the total general outlay of Ohio. North Carolina with slightly less than half the population of Ohio expended 60% of the amount ($1.4 billion) of Ohio's general expenditures. Both Washington's and Colorado's general expenditures were also proportionately higher for their respective populations than the expenditures of Ohio.

During the school year 1968-69 the State's total expenditure for elementary and secondary schools was $1.4 billion. The public school enrollment during that school year was 2,389,000 of which 1,707,000 were enrolled in elementary schools. The per pupil ADA cost was $634 which was below the national average of $680 during that year. The total revenue receipts for the State consisted of approximately 5% in federal funds, 35% State funds, and 60% local funds.

In 1969, Ohio expended $11.4 million in federal funds for community health services and maternal and child health services. Of this amount, $300,000 were spent on statewide comprehensive health planning; $1.2 million on areawide health planning; $2.8 million on comprehensive public health services; $294,000 on migrant health; $1.8 million on maternal and child health services, and $2.1 million on crippled children's services.

In terms of general welfare assistance to persons under 65 years of age, Ohio handled the greatest number of cases in 1969 among the five states. Ohio had a total of 19,500 cases which provided general assistance to 50,400 individuals. Five out of every 1,000 persons under the age of 65 years received general assistance from the State. By comparison, California's caseload per 1,000 persons was 3.7; Colorado's was 1.4; Washington 3.5. Colorado was the lowest with 0.7. The total cost for general assistance payments in the State of Ohio for the calendar year 1968 was $50 million.

State Organization

Four departments of the State government of Ohio are directly involved in delivering services to the mentally retarded: Department of Mental Hygiene and Correction; Department of Education; Department of Public Welfare; and the Department of Health. There is no separate authority at the departmental level for vocational rehabilitation.

Directors of departments, with the exception of the Department of Education, are appointed by the Governor. In the case of education, the State Board of Education is elected by the voters and the State Superintendent is appointed by the State Board. Among the five states this procedure is followed only in Colorado. Among all states, nine follow this procedure. For the most part, the remaining states have state boards appointed by the governor and the chief state school officer is either elected by the voters or appointed by the state board. In only four states does the governor appoint the superintendent of schools.

The Department of Mental Hygiene and Correction (Martin Janis, Director) is the largest operating department in the State government and is also the agency designated to administer comprehensive community mental health and comprehensive mental retardation facilities construction programs. The Department is organized into two staff divisions and five line divisions. The latter consist of the Division of Mental Hygiene, Division of Mental Retardation (Roger Gove, M. D., Commissioner), Division of Administration on Aging, Division of Correction, and Division of Psychiatric Criminology.

The Division of Mental Retardation was formerly a bureau under the Division of Mental Hygiene. By a November 1969 executive order of the Governor, the Bureau of Mental Retardation was designated the Division of Mental Retardation. The change became statutory during the 1970 session of the Legislature.

The Bureau of Planning and Grants (Dr. Wayne Chess, Chief) reports to the Division of Mental Hygiene (J. Wylie McGough, M. D., Commissioner). The facilities planning functions of the Division, particularly those authorized under P. L. 88-164, were delegated to this Bureau. The redesignation of the Bureau of Mental Retardation up to divisional level did not, at that time, include any details on the role of the Bureau of Planning and Grants in new mental retardation programs.

The Bureau of Planning and Grants, in cooperation with the other bureaus in the Department of Mental Hygiene, authored Ohio's 1969-70 comprehensive mental retardation plan which was aimed at facility construction requirements in the State. In comparison to many of the state plans in mental retardation which focus mainly on recommendations, the Ohio plan tends to focus on the resources and needs of the fifteen mental retardation zones in the State and leaves the recommendations to be derived from the priorities thus described.

The primary responsibilities of the Division of Mental Retardation include the six mental retardation institutes and state hospitals, the 88 County Boards of Mental Retardation, the zonal concept of regionalization, and the needs of the mentally retarded lying within this framework.

In addition to the agencies and departments in the State government there is a gubernatorially appointed State Mental Health and Mental Retardation Advisory Council which offers advice and assistance to the Director of Mental Hygiene on any matters relating to the Division of Mental Hygiene. The original Advisory Council was appointed in 1965 by the Director of the Division of Mental Hygiene, the Governor concurring. The new Advisory Council, which replaces the former Mental Health Facilities Advisory Council, was established in October 1969. Thirteen members have been appointed by the Governor (George Harding, Sr., M.D., Chairman).

Planning and Planning Coordination

There are four distinct planning components in the State of Ohio: (1) a Citizens' Committee component acting in an advisory capacity to the Governor; (2) a State government component, known as the Bureau of Planning and Grants, in the Department of Mental Hygiene and Correction; (3) local government components which exist in the form of County Boards of Mental Retardation; and (4) zonal components operating through the Division of Mental Retardation of the Department of Mental Hygiene and Correction. The term of the Citizens' Committee expired in 1969, however, many of its recommendations form the basis for State and local strategies toward the problems of the mentally retarded. The State Bureau and the County Boards are permanently sanctioned organizations and are presently in operation. The zonal component is based on a zonal concept for the delivery of services to the mentally retarded and is currently in the early phases of implementation.

The Citizens' Committee on Mental Retardation, chaired by the late Herschel Nisonger, was created in 1966 following a report to the Governor by the Citizens' Committee on Comprehensive Health Planning. That report also led to the creation of the Bureau of Planning and Grants in the Department of Mental Hygiene and Correction which was created to assure continued attention to long-range planning and the implementation of the recommendations of the Citizens' Committee.

The Citizens' Committee, examining both the short and long-range problems of delivering services to the mentally retarded throughout the State, was organized into fifteen zonal committees. Committees were eventually formed which were active in each of the State's 88 counties. On subject matter, the Committee's interests were organized along the lines of residential-domiciliary facilities, community training programs, protective service and public guardianship, coordination and program development, legislation, and manpower.

The first of a proposed series of reports entitled: "The Zonal Concept," consisting of the regionalization of the State into 15 zones and 88 recommendations for the implementation of programs, was the product of the subcommittee on Residential and Domiciliary Facilities, Community Training Programs, and Protective Services and Public Guardianship.

The Bureau of Planning and Grants of the Department of Mental Hygiene, acting in the capacity of staff to the Citizen's Committee and later as a line component of the Division of Mental Hygiene, received a $216,000 grant from the Federal government under the 1965 Amendments to the Social Security Act. The Bureau prepared the State's comprehensive plan to govern the administration of $550,000 allocated to Ohio for community mental retardation facilities for the fiscal year 1969. The updated 1970 plan, approved by the Mental Health Facilities Advisory Council, is the long-range extension of the $2.8 million invested in community mental retardation facilities for the five-year period ending in 1969. In the 1969-70 State plan the resources and needs of the State for the mentally retarded are listed in depth for each of the fifteen planning and service zones.

The fifteen zones in the 1969-70 State plan represent a change from the sixteen zones originally prescribed. The modification consists of slight county realignments in five zones and the major realignment of counties in the western region of the State from three to two zones. In the State plan, the Bureau explains that the change resulted from efforts by the State government to identify the most logical population center to serve as a hub for the proposed zonal headquarters and that this led to considerations of transportation ease, established and potential patterns of cooperation, population size, and the existing network of facilities and services for the mentally retarded.

The zonal concept was described a number of years after county boards of mental retardation were mandated by the State Legislature. As a consequence, county boards, partially financed by property taxes, have been in effect while the zonal structure was being designed. Zonal organizations will be State dependent components, presumably to be administered by assistant or regional commissioners for the Division of Mental Retardation, whereas the county boards will be county dependent organizational units.

The concept of zones in Ohio most closely resembles the four region concept of North Carolina where regional commissioners preside over local multi-county areas. The Ohio concept differs in the territorial scope of each of the zones. Where the 100 counties of the State of North Carolina are divided into four large regions, the territorialization of Ohio is smaller; i.e., 15 zones for 88 counties. The difference in territorial scope of the regions in Ohio compared to North Carolina is lessened by the fact that North Carolina has half the population of Ohio. Regional commissioners in North Carolina will preside over the demands of an average of 1,270,000 persons while the "commissioners" of Ohio will be responsible for the needs of approximately 710,000 persons per zone.

The considerations in Ohio that led to the consolidation of sixteen zones into fifteen zones, particularly transportation ease and the established and potential patterns of cooperation, are criteria which do not appear in the plans of the State of California. In California, the criteria for the establishment of areas are based primarily on the regional precidents established by Comprehensive Health Planning, the "Partnership in Health" program sponsored by the Federal government. The Comprehensive Health Planning criteria in California consist of population and territory and, in some cases, the economic status of people within a given territory.

In 1968, the Citizens' Committee on Mental Retardation, under five subject headings, (planning, residential and community facilities, protective services and guardianship, community training programs, and finances) offered a number of recommendations to the Governor among which were the following:

On the subject of the zonal concept...

1. The State of Ohio should be geographically divided into planning and programming zones.
2. Comprehensive services should be available in each zone.
3. In each zone, a headquarters should be established.

On the subject of residential and domiciliary facilities and programs...

1. Ohio communities should assume the major leadership responsibility in planning and developing special-purpose as well as domiciliary facilities for the mentally retarded.
2. Within five years, the State in cooperation with its communities, should construct at least six new residential facilities, one each in the northwest, west central, southwest, and southeast, and two in the northeast section of Ohio.
3. Consistent with the zonal concept, a reorganization of each of the institutions directed toward the grouping of residents on a geographical basis in units not exceeding 500 persons.

On the subject of protective service...

1. The Department of Mental Hygiene should develop a plan, based on the data and recommendations of a protective service project, for protective service of the mentally retarded and their families.
2. The Chief of the Bureau of Mental Retardation (since redesignated the Commissioner of the Division of Mental Retardation) should be authorized to exercise legal intervention and serve as a public guardian when necessary for individuals whom the courts have found to be mentally incompetent but not in need of commitment to an institution.

On the subject of community training programs...

1. Each county should develop its facilities and services in accordance with a comprehensive and long-range plan which should be revised each year and closely coordinated with the county's mental health and mental retardation plan and the State's comprehensive mental retardation plan.

2. A network of day care centers for the mentally retarded should be established.
3. Mandatory education and training programs for the moderately and severely retarded should be further studied and researched.

On the subject of finances...

1. State and local tax monies communsurate with need and sound programs must be made available.
2. Local boards of education should continue to contribute to the support of community training programs for school-age mentally retarded pupils through the present system of tuition payments.

Legislation

State-county training programs for the mentally retarded were first authorized by the Ohio General Assembly in 1951. At that time, the recipients of such services were to be mentally deficient youth under 21 years of age including those adjudged by proper authorities to be ineligible for enrollment in public school or, if not of school age, to have an intelligence quotient below fifty. The training programs were authorized and supervised by the Commissioner of Mental Hygiene and administered by the county welfare board or public children's agency. An Advisory Council was appointed by the Director of Public Welfare to assist the Commissioner of Mental Hygiene in the establishment and formulation of policies for the operation of these training programs.

In a series of subsequent enactments covering a span of 14 years, the training programs were expanded to include a workshop authority and the recipients of services were redefined as persons of all ages and not only youth under 21 years of age. The Advisory Council, repealed in 1963, was to be re-established in another form in 1965.

A parallel program under the jurisdiction of local district school boards appeared in 1957 for the mentally retarded who were eligible for enrollment in public schools. Under this enactment school boards were permitted to establish special schools or facilities for the mentally retarded, to provide transportation for such pupils, and to contract with child welfare boards, boards for county commissioners, or any municipal corporation to provide training for these individuals. The language of the bill left room for interpretation as to whether transportation was to be provided at no cost or for a fee. Seven years later, in 1964, an opinion solicited from the Attorney General interpreted the authorization for transportation to be without cost.

The training authority for mentally retarded persons in Ohio was based on these enactments up to 1967 at which time a series of bills appeared which modified both the scope and the authority over community programs for the mentally retarded.

Amended Senate Bill 169, filed on July 27, 1967, created county boards of mental retardation and transferred to these boards the administrative responsibilities and duties for the training and workshop programs formerly held by the county welfare boards or public welfare agencies. In addition, the local units were authorized to levy property taxes in excess of the ten-mill limitation for the maintenance and operation of schools, training centers, workshops, clinics, and residential facilities for the mentally retarded. The "169" county boards, which now exist in all 88 counties of Ohio are the community components for delivering services to the trainable mentally retarded. Their revenue authority is based on property levies, as is the authority of the county boards in the State of Washington, but the Ohio boards can exceed the ten-mill limitation. Their scope of authority is as broad as the Community Centered Programs of Colorado but they are county dependent organizations as opposed to State dependency in Colorado.

Excerpts from S. B. 169 and other selected enactments are cited as follows:

Amended Senate Bill No. 169 - County Boards of Mental Retardation, 1967

> Amended Senate Bill 169, which went into effect on October 25, 1967, was enacted by the 107th Ohio General Assembly to create in each county a County Board of Mental Retardation. The Bill specified that the County Boards, subject to the rules, regulations, and standards of the Commissioner of

Mental Hygiene, shall administer the sections of the Ohio Revised Code pertaining to training and workshop programs for the mentally retarded. Funds for the administration and provision of such services were to be obtained from a ten-mill property tax or a tax in excess of such a limitation if two-thirds of all members of the County Board declare that revenues will be insufficient for these programs. The County Boards replaced the county child welfare agencies on community programs for the mentally retarded.

County Boards consist of seven members, five of whom are appointed by the board of county commissioners and the other two are the county probate judge or his delegate and one other person appointed by him. At least one member is to be the parent of a mentally retarded person.

County Boards were directed to employ personnel and provide services, facilities, and transportation, and equipment and funds as are necessary for the operation of training centers and workshops.

The Bill directs the Commissioner of Mental Hygiene to establish training centers and workshops in counties and districts for the special training of mentally deficient persons ineligible for enrollment in public school or, if not of school age, unemployable because of mental deficiency of such a nature and to such a degree that special training is necessary.

The Bill further directs the Commissioner of Mental Hygiene to accept the petition of the parents or guardians of eight or more mentally deficient persons or persons of similar handicap in any county for special programs. The Commissioner is directed to take action as he deems necessary for the training of these persons to the extent that funds are available.

Amended House Bill No. 648 - Community Mental Health and Mental Retardation Act, 1967.

Amended House Bill No. 648, filed on the same day as S. B. 169, decentralized the administration of federally supported community mental health and mental retardation programs by encouraging the development of comprehensive programs under local auspices.

The Bill specified that community mental health and mental retardation programs shall be established in any county or combination of counties having a population of at least 50,000 to provide community services for mentally ill, mentally retarded, and emotionally disturbed persons. It further specified that the Commissioner of Mental Hygiene may authorize any county or combination of counties having a population less than 50,000 to establish such programs.

Boards, ranging in membership from 9 to 15 members, depending upon sponsorship by single or joint counties, are appointed by the Commissioner of Mental Hygiene and the boards of county commissioners; one-third by the former and the remaining by the latter. Two members of the board shall be practicing physicians, one of whom shall be a psychiatrist or pediatrician, and at least one member shall be a probate judge of a participating county or his designee.

The Boards were directed to undertake the following duties with the exception of programs authorized under Chapter 5127 of the Ohio Revised Code (the authority of the County Boards of Mental Retardation specified in S. B. 169):

1. Review and evaluate community mental health and mental retardation services and facilities and submit recommendations for reimbursement from State funds those programs authorized under certain sections of the Revised Code.
2. Coordinate the planning for community mental health and retardation facilities, services, and programs seeking state reimbursement.
3. Enter into contracts with state hospitals, other public agencies or with private or voluntary hospitals and other private or voluntary nonprofit agencies for the provision of mental health and mental retardation service and facilities.
4. Various other responsibilities having to do with the appointment of an administrator, approving salary schedules, and the like.

Assistance to be provided to counties by the Division of Mental Hygiene further distinguishes this Bill from S. B. 169. The Bill specifies that the Division of Mental Hygiene shall provide financial assistance to Community Mental Health and Mental Retardation Boards from funds appropriated for that purpose by the General Assembly. Services could include out-patient diagnosis and treatment, in-patient care and treatment, partial hospitalization, rehabilitation, consultation to community agencies and the general public, information and education and other prevent services, emergency care, research and training, and other programs, facilities, and services approved by the Board and the Commissioner.

The Bill provides a minimum of $.50 per capita and a maximum of $1 per capita for each county resident. Within this limitation the State pays 75% of all allowable expenses for the operation of these programs. The Bill also authorizes the use of State monies on an equal matching basis with community monies for the construction of community mental health and mental retardation facilities.

Amended House Bill 223 - State Mental Health and Mental Retardation Advisory Council, 1969.

The duties of the Mental Health and Mental Retardation Advisory Council, to be appointed by the Governor, were expanded by H. B. 223 which went into effect on 24 October 1969. The original Advisory Council was appointed by the Director of the Department of Mental Hygiene with the concurrence of the Governor.

The Bill specifies that the Advisory Council may offer advice and assistance to the Director or the Commissioner of Mental Hygiene on any matters relating to the functions of the Division of Mental Hygiene including any program developed under Title I, Part C, and Title II of P. L. 88-164.

The Advisory Council will have not more than eleven members and will include four persons having demonstrated knowledge and interest in mental health with two of those persons being psychiatrists. Four persons shall have demonstrated knowledge and interest in mental retardation. There will also be three persons serving on county mental health and mental retardation boards.

Substitute Senate Bill No. 367 - Licensing of Residental Care Facilities for the Mentally Retarded, 1970.

S. B. 367, which became effective on June 8, 1970, directed the Division of Mental Retardation to supervise and annually inspect and license all residental care facilities that receive

> mentally retarded persons for care. The Division shall adopt regulations prescribing minimum standards for any residential care facility and regulations establishing procedures and fees for issuing licenses. Licenses shall expire one year from the date of issuance and may be renewed.

The rules and regulations of the Bureau of Mental Retardation (now the Division of Mental Retardation) of the Division of Mental Hygiene in existence prior to the passage of S. B. 169 reflect the applicable sections of the Ohio Revised Code pertaining to community programs for the mentally retarded. The four service programs cited in the regulations are as follows:

1. Community Classes - Rule MHh-1-05

   Community classes are defined as those programs concerned with the instruction of school age children excluded from the public school, and for the mentally retarded beyond compulsory school age, but not beyond the age of 21 years. Eligibility starts at the age of 6.

   The chronological age range within the Community Class shall not exceed 5 years between the youngest and oldest members of a given class. Class minimum shall be 5; maximum, 12.

2. Workshop Programs - Rule MHh-1-18

   A workshop, carrying out a defined program of rehabilitation for individuals whose capacity has been impaired because of mental retardation, may provide remunerative employment and/or other training, occupational counseling, evaluative or those therapeutic services deemed necessary for an individual to live within his potential. Individuals with an I. Q. above 55 but below 80 may be enrolled provided there is no waiting list from the Community Class program.

3. Adult Activity Center - Rule MHh-1-27

   Adult Activities Centers are programs of activities and training for individuals whose capacity has been so impaired to prohibit them from profiting from Community Classes or workshop programs.

4. Developmental Services for Pre-School and School Age Children - Rule MHh-1-34

   These programs constitute special training and services enabling the mentally retarded to become accepted by society and shall be considered in the establishment and operation of each training center.

Services

Institutes and State Hospitals

There are six public residential institutions for the mentally retarded in the State of Ohio. Four are institutes and two are state hospitals. Two other facilities, primarily for mentally ill and tubercular patients, serve a dual purpose by admitting mentally retarded persons.

In 1968, the resident population of the four institutes (Apple Creek State Institute, Columbus State Institute, Gallipolis State Institute, and Orient State Institute) was 9,064 or 92% of the 9,844 total public residential facility population in the State. The remaining 780 were housed at the Broadview Center in Brecksville (81), the Mt. Vernon State Hospital (488), and the dual-purpose Cambridge State Hospital (211). Nine mentally retarded tubercular patients at the Springview Hospital in Dayton are not included in the above.

Orient State, with a resident population 3,008, is the largest of the institutes. One-third of all the mentally retarded in public facilities in Ohio were residents in Orient

State. The smallest of the institutes is Apple Creek with a resident population of 1,830. In 1968, all four institutes were overcommitted from $5\frac{1}{2}\%$ (Apple Creek) to 12.9% (Gallipolis) above APA rated bed capacities. The Broadview Center and Mr. Vernon State Hospital were the only two facilities operating below rated capacity.

Since 1965, Ohio has been experiencing a decline in State facility resident population. During the period between 1965 and 1969, the resident population dropped 409 or 4% of the total institutional population. The utilization rate per 100,000 residents in the State dropped from 98.6 to approximately 91.1 during that same period of time. Much of this decline has been attributed to the development of community programs throughout the State. An accelerated decline has been estimated based on the growth of residential services in various counties.

The utilization rate in State institutions has dropped below the one space per thousand guideline suggested by the Citizens' Committee in 1968. It is not known to what extent the difference is taken up by community nursing homes, foster homes, group homes, boarding homes, etc., for the mentally retarded six years of age and older. Private facilities which handle most of the cases under six years (the age of eligibility for admission to a State facility) probably account for a small portion of the difference between the suggested 100 residents and the actual 91.1 residents per 100,000 population.

Ohio, having circumvented the problem of pledging its credit to construct facilities, is in the position, which it was not in before, to consider building new residential facilities in accordance with the recommendations of the Citizens' Committee. The Committee recommended that the populations of each of the four institutes should be reduced to a maximum of 500 within ten years and that, within five years, six new residential facilities should be constructed in zones where none are currently located.

The appropriations act for capital improvements of the 108th General Assembly, authorized $151 million for the biennium ending June 1971 for the construction of mental health and mental retardation facilities. Of that amount, $23 million were authorized for residential facilities for the mentally retarded (not for the existing Institutes or State Hospitals which were provided separate funds).

The Division of Mental Retardation estimates that 17,177 mentally retarded persons will be served in residential facilities by 1975. According to the Division's definition, these include the large, residential or multi-purpose facilities, accommodating up to 500 persons, and the community based domiciliary facilities such as small group homes, foster homes, or boarding homes.

Community Programs

In Ohio all services for the mentally retarded other than those provided by the State institutes and hospitals fall under the jurisdiction of either the Department of Education or the Department of Mental Hygiene and Correction.

School age, educable mentally retarded youngsters, those with I.Q.'s between 50 and 80, are the responsibility of the Division of Special Education of the Department of Education. Youngsters who are excluded from school, children of pre-school age, youth, and adults are the responsibility of the Department of Mental Hygiene and Correction. These responsibilities are exercised through tax supported County Boards of Mental Retardation or State funded County Boards of Mental Health and Mental Retardation. The former are involved in the training, care, and placement of the mentally retarded in community facilities. The chief responsibilities of the latter are in the areas of planning, grants management, and program accountability of operating and construction funds for local programs other than those authorized to the County Boards.

In 1969, there were 12,637 persons enrolled in community programs. The total cost of the program was $11.6 million of which $2.7 million (or 23.4%) was subsidized by the State, $2.8 million (or 24%) was paid by school districts, and $6.1 million (or 52.6%) paid by the counties.

Enrollment distribution by type of program was as follows:

Pre-school and school age enrollees	
Home training	2,573
Pre-school	605

Community clases	6,586	
Developmental classes	779	
School and pre-school total		10,543 (83% of all enrollees)
Adult enrollees		
Sheltered workshops	1,484	
Activity centers	610	
Adult total		2,094 (17% of all enrollees)

According to the Division of Mental Retardation, enrollments in community programs almost tripled during the five-year period between 1964, when there were 4,451 enrollees, and 1969 when there were 12,637 enrollees. The annual increase in enrollments ranged from a high of 33% in 1965 to slightly under 10% in 1968. In 1969, the increase was slightly under 20%.

Notwithstanding the gains in enrollment, the Division of Mental Retardation estimated, in 1968, that only partial needs were being met in the community. School age community classes, at that time, were estimated to be serving 76% of total needs. Home training services, pre-school community classes, and adult services were each meeting less than 10% of estimated needs. By comparison, residential facilities, both public and private, were estimated to be serving 67% of total needs and public school classes were serving 35% of the educable mentally retarded population.

In 1968, the Division of Mental Retardation estimated that 86,288 persons in Ohio required home training services, community classes, and adult services. The 12,637 enrollees in community programs in 1969 accounted for approximately 15% of total estimated needs.

In 1969 the counties with community programs were as follows:

Pre-school classes	26 counties	62 classes
Developmental classes	20 counties	62 classes
Community classes	84 counties	562 classes

Sheltered workshops	30 counties	- classes
Adult activity centers	32 counties	- classes
Home training	31 counties	- classes

Eight counties had more than 500 enrollees in community programs in 1969. Cuyahoga County with an enrollment of 1,533 expended a total of $1,165,000 in State and local funds during 1968-69 on community programs. Franklin County ranked second in terms of enrollment with 1,070 but expended a total of $1,229,000 during that same year. The investment of the local government in Cuyahoga County was $400,000 or 34.3% of total costs compared to Franklin County's expenditure of $813,000 which represented 66.2% of total costs.

In descending order, the enrollment and total program costs of the six remaining counties with community program enrollments over 500 were: Summit County (839 enrollees, $661,000); Lucas County (768 enrollees, $893,000); Montgomery County (737 enrollees, $410,000); Hamilton County (686 enrollees, $642,000); Lorain County (629 enrollees, $324,000); and Stark County (524 enrollees, $445,000).

In 1969, 66 out of 88 counties enacted a special property tax millage for estimated excesses over base revenues for operating programs for the mentally retarded. Twenty—four counties, not necessarily the same ones, enacted special construction levies for mental retardation facilities. The funds expected from special levies amounted to $7.9 million for operational programs and $7.1 million for construction programs. Twenty counties enacted neither.

Three of the ten most populated counties did not enact special operating or construction levies. All three, Cuyahoga, Hamilton, and Montgomery, contributed one-third or less to community mental retardation programs in their respective counties during 1968-69.

Special Education

In 1969, there were 38,746 educable mentally retarded children and youth enrolled in special classes in 451 local, city, and village school districts in Ohio. The annual cost per student ranged between $4,050 and $15,000 per annum depending upon the qualifications of the school districts for State financial aid.

In Ohio, special classes for the educable mentally retarded are not mandated to the local school districts. Those districts electing to establish special classes are provided with State assistance on the basis of a formula which includes both the qualification of the teaching unit and the financial need of the sponsoring district. Funds thus received are included in the overall school budget.

According to the Division of Special Education of the Department of Education, 85% of all school districts have at least one teaching unit for the educable mentally retarded.

Hamilton County, the second largest county in the State, led the State with 5,816 EMR enrollees in 1969. Based on projections of the total number of mentally retarded with I.Q.'s above 50 living in the county, this enrollment represented 44% of all EMR in the county.

Cuyahoga County, the State's largest county and the population center of the Cleveland multi-county metropolitan area, had the lowest percentage of the EMR enrollees based on estimates of total borderline and mildly mentally retarded in the county. In 1969, there were 3,702 EMR enrollments compared to a total estimated population of 16,988 educable mentally retarded in the county.

In addition to stimulating local interest in programs for the mentally retarded with supplementary funding, the State Division of Special Education under the auspices of the U. S. Office of Education provides consultation service to local school districts through 59 field consultants. At the present time this interim network covers 44 of the State's 88 counties. Each of these supervisors, who have at least three years of EMR teaching experience, help school districts establish program objectives and assist classes in the application of new methods for managing and teaching the mentally retarded.

The revised plans of the Division of Special Education have appeared in a document entitled: "Planning for the Education of the Handicapped Child in Ohio, 1970."

In that document, a program to provide special classes for approximately 110,000 educable mentally retarded students by 1975 is proposed.

Sources

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5. Rules, Regulations, and Standards for the Establishment and Operation of Programs for Training the Mentally Retarded. Bureau of Mental Retardation, Ohio Department of Mental Hygiene and Correction. October 1967.
6. Rules, Regulations, and Standards for the Establishment and Operation of Community Mental Health and Mental Retardation Services and Facilities. Bureau of Community Services, Ohio Department of Mental Hygiene and Correction. May 1968.
7. Special Education Directory, 1968-1969. Division of Special Education, Columbus. November 1968.

4. NORTH CAROLINA

General Characteristics of the State

Area, Population, and Income

North Carolina, covering a land area of 48,880 square miles, ranks 29th in size among the 51 (including the District of Columbia) states. On an average the north-south distance is approximately 100 miles. Its breadth from east to west is 503 miles, greater than any other state east of the Mississippi River. Of the five states being studied it ranks next smallest in size to Ohio.

The 5,082,000 inhabitants of North Carolina in 1970 place the state 12th in population nationally and third among the five states. North Carolina had one-fourth the population of California but more than twice the population of Colorado. A population density of 102.9 persons per square mile in 1967 places North Carolina very close to the population density of California.

The topographic profile of North Carolina partially explains the density similarity of North Carolina to California. The northeast to southwest axis of the state, containing the largest concentrations of population, is not typical of the sparsely settled areas along the Atlantic seaboard or the Tennessee western border.

The eastern seaboard is known as the Tidewater region. To the west of it lies the Upper Coastal Plain. The Piedmont plateau, the densest population corridor, lies in the center of the State; the Appalachian Mountains on the west. Thus, beginning at sea level on the eastern edge, the topography of the state rises in elevation and increases in irregularity until it reaches its maximum height and ruggedness in the Appalachians. These four areas also mark the four distinct socio-economic divisions of the state.

The Tidewater region is the vast low lying, flat and swampy country of the 250 mile long Atlantic coastline of North Carolina. Its topographic and social profiles aredifferent from all other areas of the State.

The Upper Coastal Plain, occupying almost a third of the land area of the state, is an area of level and gently rolling hills. This area contributes to the high agricultural economy of the state. The very large number of farms, however, considerably depresses income per unit farm.

The Piedmont plateau lies between the western boundary of the Upper Coastal Plain and the Blue Ridge Mountains. It is the largest and most densely populated area of the state. The Appalachian Mountain area, or the Carolina Highlands, is walled off from the east by the Blue Ridge Mountains. This area has always been slow in economic and social development because of its isolation and rugged terrain.

In 1960 the non-white population of North Carolina stood at about 25%. The proportion was about the same for urban and rural areas. However, the rural non-white population was located mostly along the eastern Upper Coastal Plain and Tidewater area and the rural white population mostly in the western mountain region.

In 1967 North Carolina ranked 16th among all states in terms of gross personal income with a total of $12 billion but dropped significantly to 44th place in terms of personal per capita income. The personal per capita income of $2,439 was considerably below the 1967 national average of $3,159. Colorado personal per capita income was slightly below the national average that year. All of the three other states being studied placed higher than the national average.

The Bureau of the Budget listed seven Standard Metropolitan Statistical Areas in North Carolina in 1967. The largest of these was the Greensboro-Winston Salem-High Point SMSA, located in the north central section of the Piedmont plateau, with a population in excess of one-half million. The Charlotte SMSA, to the southwest of Greensboro, was second in size with a 1968 population of 388,000. The remaining five SMSA's with populations ranging from 202,000 to 97,000 were Raleigh, Fayetteville, Durham, Asheville, and Wilmington. All are located within the boundaries of the State.

Local Governments and Districts

North Carolina is one of the twenty-nine states without any form of township government. The smallest local unit is the municipality (cities, towns, and incorporated villages) of which there are 437. Fifteen of these municipalities extend into two or more of the 100 counties in the State. North Carolina has the greatest number of county governments among the five states being studied and more than 43 of the 51 states in the nation. California, by comparison, with a much larger population, is subdivided into 58 counties.

The 198 public school districts in North Carolina, unlike the school districts in all other states except three, are not independent units but are agencies of county governments. This applies to the 69 units which administer schools in or near various municipalities as well as the county school units.

Typically, powers of county commissions are spelled out by the Legislature. County boards administer State programs, levy taxes, appropriate funds for local support of programs, and furnish services of their own, as permitted by law. The county boards have options on the extent to which funds are appropriated. This often determines the amount of local participation in State and Federal programs. In North Carolina, counties may be created, changed, or abolished at the will of the Legislature.

Most counties have appointed Boards of Education. The board generally appoints the County School Superintendent.

Every county constitutes or is embraced in a public health district. If a single county constitutes a district, there is a County Board of Health, consisting of the

Chairman of the County Board of Commissioners, the County Superintendent of Schools, and the Mayor of the County seat, who act as ex officio members of the Board. Two practicing physicians and one dentist are, in turn, appointed by the ex officio members. The Health Officer is recommended by the Board to the County Commissioners. Each county also has a Board of Public Welfare. Its superintendent is named by the County Board of Commissioners.

Revenue and Expenditures

North Carolina's total revenue amounted to 2 billion dollars in 1967, placing it 15th among all States. However, based on total population, the per capita revenue dropped in the State to 50th place. The State's low ranking in revenue was not offset by federal funding which, on a per capita basis, placed North Carolina in 42nd place amongst subsidy recipients.

Among the seventeen states in the southern census region, North Carolina ranked next to last in per capita general revenue received and never better than 13th in general revenue per thousand dollars income, per capita general expenditures, or per capita general expenditures per thousand dollars income.

Total expenditures of both the State and local governments in 1967 was $1.9 billion. The combined State and local indebtedness at that same period of time was $1.5 billion.

North Carolina's expenditures on behalf of local governments in 1967 was $538 million or 43.6% of the total State general expenditure. The State of Ohio by comparison, with a population two times that of North Carolina, expended $643 million on local governments or only 32.8% of total State expenditures. In terms of percentage participation of the State in local finances, North Carolina led the five states being studied. California ran second with 41% of total expenditures made on behalf of local governments; Ohio was lowest.

Of the $538 million expended for local governments, 96% or $517 million was disbursed to county governments and the balance to municipalities and various special districts. Of the monies given to county governments $410 million were expended for education, $84 million for public welfare, and $3 million for health functions. The large educational expenditure reflects the dependent relationship of the school district with the county.

Comparing these expenditures again with the doubly populated State of Ohio, North Carolina educational expenditures exceeded those of Ohio. The $338 million that were expended for education in Ohio were disbursed primarily to school districts with about 3% going to municipalities. In North Carolina the education disbursements were given to counties.

State Organization

The agencies and departments of the Raleigh seated North Carolina State Government most involved in providing services to the mentally retarded are the Department of Mental Health (Dr. Eugene Hargrove, Commissioner), Department of Public Instruction (A. Craig Phillips, Superintendent), Department of Social Services (Clifton Craig, Commissioner), Board of Juvenile Correction (Blaine Madison, Commissioner), Medical Care Commission (William F. Henderson, Executive Secretary), Board of Health (Dr. Jacob Kooman, Director), and the Council on Mental Retardation (Robert L. Denny, Executive Director). The directors or administrators of all major boards and departments are appointed by the governor with the exception of the elected Superintendent of Public Instruction.

In some of these State agencies, the problems of the mentally retarded have been assigned to special positions. In the Department of Mental Health, the position of Deputy Commissioner of Mental Retardation (Dr. Robert Cohen) has been established for those problems peculiar to the area of mental retardation. In the Department of Health, a Mental Retardation Section (Dr. Robert Neely, Chief) was established in the

Personal Health Division in December 1969. The problems of special education are administered in the Division of Special Education (George Kahdy, Director) of the Department of Public Instruction.

In North Carolina the functions of vocational education and rehabilitation are located in the Department of Public Instruction. Programs of vocational rehabilitation are administered by the Division of Vocational Rehabilitation (Claude Myer, State Director).

Construction grants to hospitals and other health centers (including construction authorized under P. L. 88-164, The Mental Retardation Facilities Construction Act) are administered by the Medical Care Commission under an organizational arrangement unusual in the five states being studied. The Commission, not an advisory body, receives and disburses Federal grants which may be used on a matching basis to construct hospitals, health centers, schools of nursing, mental health facilities, nursing homes, and mental retardation facilities. The Commission is the Hill-Burton agent for the State. The Commission is also involved in the licensing of hospitals and the administration of a State-financed loan fund for students in medically related professions.

The North Carolina Board of Juvenile Correction is unique among the five states in its commitment to the problems of delinquent youth who are mildly or moderately retarded. The Board administers eight (8) special residential schools located throughout the State which are involved in the treatment, education, and rehabilitation of youngsters under the age of 18 who have been committed to the care of the Board by the Courts of the State. All of the correctional schools provide service to the mildly and moderately retarded through special education classes, casework services, vocational training and counseling, and guidance counseling. In cases where mental retardation is accompanied by physical or emotional disorders, the youngsters are placed in the Juvenile Evaluation Center, a special organizational unit for more intensive clinical services. In cases where mental retardation is accompanied by very aggressive behavior, the youngsters are placed in the C. A. Dillon School where one unit is specially programmed and staffed to the particular needs of the retarded, aggressive delinquent.

The unit at the C. A. Dillon School, although specifically designed and programmed to the needs of this highly classified group of youngsters, is both a self-contained unit for students who are unable to function successfully in the total school program or an integrated unit if the needs of the individual can be served by other areas of the services program. Youngsters in the retarded unit of the Dillon School are not identified to the other youngsters as mentally retarded and the integration of these students with the rest of the school population depends solely on the ability of the youngster to benefit from the services program of the other units of the school.

The North Carolina Council of Mental Retardation, consisting of gubernatorial appointees and a permanent staff, is also unusual among the five states because of its durability and level of funding. The Council was created by an act of the General Assembly of North Carolina in 1963 following a recommendation made by the Governor's Commission appointed in February 1962 for the specific purpose of presenting the most pressing needs of the mentally retarded in the State of North Carolina. Among these was a general recommendation for the establishment of a group to meet the continuing need for coordination and planning.

The Council membership, as legislatively specified, is appointed by the Governor and is composed of two persons who at the time of appointment are members of the Senate, two persons who at the time of their appointment are members of the House of Representatives, a representative of the State Board of Health, a representative of the Department of Mental Health, a representative of the State Board of Public Welfare, a representative of the State Board of Education, a representative of the State Board of Juvenile Correction and Training, a representative of the North Caroline Association of Retarded Children, and eight other persons appointed without regard to employment or professional association. At this time, seven years after it was first established, the Council is still in existence.

From the original 1963 budget authorization of $40,000, the Council budget has grown to a 1967-1969 total budget figure of $251,456. (The State's "A" Budget is for continuation of the agency activities at their previous level and for maintenance of existing programs; the "B" Budget contains recommendations for program expansion, for new programs and for additional personnel.)

The Advisory Budget Commission of North Carolina has approved an "A" Budget figure of $166,000 for the year 1969-1970 and $170,009 for year 1970-1971. The "B" Budget recommendations amount to $49,541 for each year of the 1969-1971 biennium, with the total "B" Budget recommended appropriation of $99,082 going to create four additional positions for local community coordinators and one for an additional stenographer. The total recommended "A" and "B" Budgets for the Council for 1969-1971, therefore, amount to a total of $435,091 for the biennium. This represents a general increase of $183,635 over 1967-1969 appropriations.

The Council, without authority to act as its own fiscal agent, depended upon the Department of Mental Health for the handling of funds. In 1969 the assignment to act as fiscal agent for the Council was transferred to the Department of Administration.

The designated State agent for handling funds disbursed through the authority of P. L. 88-164 was the Medical Care Commission. The designated agent for the implementation of comprehensive State planning for the mentally retarded under P. L. 88-156 was the Department of Mental Health. When this study was conducted, the State agent for P. L. 91-517, the Developmental Disabilities Services and Facilities Construction Amendments of 1970, had not been designated.

The Office of Comprehensive Health Planning (Dr. Jacob Kooman, Director), located in the Department of Administration, has not been directly involved in the problems of or programs for the mentally retarded in North Carolina. They have been sponsoring a task force on screening and early detection concerned primarily with perceptual disorders. The report of the task force was due in late 1970.

Planning and Planning Coordination

The North Carolina Council on Mental Retardation, since 1963, has undertaken the tasks of planning and coordination at both the inter-agency and the county levels. Of the five states being studied, North Carolina is the only state with a permanent planning and coordination organization not reporting directly to one of the state agencies and the only state-supported organization working directly with local service units.

In addition to a staff based in Raleigh the Council employs a staff of regional supervisors and area coordinators. The four regional supervisors are responsible for the planning and coordination of programs in each of the State's four planning and service regions. The supervisor of the Eastern Region is based at the Caswell Center, one of the State's four residential institutions; the Western Region supervisor at the Western Carolina Center; the South Central Region supervisor at the O'Berry Center; and the North Central Region supervisor at the Murdoch Center.

Activities within regions are assigned to the thirteen area coordinators employed by the Council or the six area coordinators sponsored by other agencies.

County appointed and supported planning units exist in the form of County Councils on Mental Retardation in approximately 83 of the State's one hundred counties. Two of the councils serve multi-county areas; one a six county area; the other a seven county area.

Departmental planning activities are usually confined to the specific programs of a particular department. In the case of the Department of Mental Health, which had been designated the responsible agency for the implementation of the comprehensive state plan, the planning function is broader than in other departments involved in problems of the mentally retarded. The role of the Deputy Commissioner of Mental Retardation in the Department of Mental Health, for example, is described as one of planning, standard setting, quality control, development, and improvement of statewide programs in mental retardation including coordination of programs of the State in state institutions and programs developed at the community level in conjunction with local authorities.

On the surface the missions assigned to the Council on Mental Retardation and the Department of Mental Health Deputy Commission of Mental Retardation are quite similar. The specific duties of the latter do not completely clarify the relationship between the two groups and how they will work together to serve the State population. It is possible that the requirement in P. L. 91-517 for a state plan will help to clarify this situation, particularly the section of the public law which requires each state to designate a state planning and advisory council to be responsible for submitting revisions of the state plan and the state agency or agencies which shall administer or supervise the administration of the state plan. Presumably, the Medical Care Commission will be designated as the responsible State agency for administering and supervising construction grants.

Three reports of historical interest to the mental retardation planning ventures of the State are the original Governor's Committee report which was prepared by a commission of citizens during 1962, the comprehensive State plan "Mandate for Tomorrow" prepared by the Council on Mental Retardation, and the State construction plan "State Plan for the Planning and Construction of Facilities for the Mentally Retarded" prepared by the North Carolina Medical Care Commission. Both of the latter were completed in the latter part of 1965.

In reviewing the planning activities of five states, it appears that North Carolina's "Mandate" and construction plan and Ohio's "Zonal Concept" are more current than the original comprehensive plans of California and Colorado. This might be due to the fact that there might have been a commitment to planning in North Carolina which didn't exist in California or Colorado or the fact that the Council, which helped develop the original plan, is still authorized to plan and coordinate programs for the mentally retarded.

Whatever the case, "Mandate" brought forth a number of findings and recommendations many of which are visible in North Carolina today. Some of the recommendations in the "Mandate" are listed below:

1. Expand maternal and child care to low income families and other "high risk" areas.
2. Develop family planning programs which emphasize the social and economic benefits of planned parenthood.
3. Encourage the Eugenics Board of North Carolina to develop more effective sterilization programs.
4. Develop a state-wide genetics counseling program
5. Establish twenty additional child health supervisory clinics.

6. Institute dentistry programs for the mentally retarded.
7. Conduct physical, mental, social, and environmental evaluations of each child in the State prior to entering school and conduct complete diagnostic evaluations on each child before assignment to special classes for the mentally or physically handicapped.
8. Consider the transportation, lack of community resource, and lack of trained manpower problems of the nine Developmental Evaluation Clinics of the State.
9. Develop alternatives to residential care for older retardates.

The recommendations in "Mandate for Tomorrow" continue with problems of residential care programs, social service programs, foster care, day care, recreation, special education, vocational training and placement, manpower, and the various barriers that exist in providing services to the mentally retarded.

Legislation

In 1968, the North Carolina Council on Mental Retardation, reporting on progress made under P. L.'s 88-156 and 89-97, the Federal authority for sponsoring planning and implementation programs for the mentally retarded, listed the following legislative actions that were initiated or enacted as a result of the comprehensive planning program:

1. School attendance - provide for the complete evaluation of a child before an arbitrary decision could be made to exclude a retarded or otherwise handicapped child from attending school and provide for an appeal mechanism by the parents in the event the child is excluded. This bill was to be introduced in the 1969 Session of the General Assembly.
2. Child abuse - The North Carolina General Assembly passed a permissive law in 1967 providing immunity to professionals reporting cases of child abuse.
3. Pilot community mental retardation complexes - The General Assembly passed an act to approve the construction of pilot community mental retardation complexes in the Mecklenburg County/Charlotte area and the Guilford County/Greensboro area (State funds, $75,020; Federal, $211,420; local, $54,560).

4. Scholarships - A bienniel appropriation of $200,000 was established by the 1967 General Assembly for loans and scholarships for training teachers of the mentally retarded.
5. Personal surrogate - The Institute of Government at the University of North Carolina, Chapel Hill was drafting a proposal to provide guardianship, conservatorship, and advice and guidance to the adult retardate.
6. Residential and day care subsidies - The 1967 General Assembly appropriated $480,000 for the biennium for monthly grants-in-aid of $40 per person to be paid to a day-care facility for moderately and severely retarded children and $120 to private facilities serving moderately and severely retarded children (under six years of age).
7. Public school education - The Council endorsed the budget request of the Board of Education which included a complete evaluation of a child prior to placement in a special education class, the increase of teachers for the mentally retarded, and the development of instructional materials for the mentally retarded.
8. Genetics counseling and the expension of the Developmental Evaluation Clinics - Passed into law by the 1967 General Assembly.
9. Council staff - An increase in the Council staff was being proposed so that additional local coordinators and clerical staff could be added to the roster which then included a career manpower specialist, a public information officer, two regional coordinators, and eight local coordinators.
10. Public school education study - A study commission was created for the purpose of examining the public school system in North Carolina. The published report included recommendations such as the guarantee of bus transportation to and from school, the creation of kindergartens in the public schools, and better screening for early detection of learning difficulties.

Some of the legislative enactments resulting from comprehensive state planning during the 1960's are listed below. A selection of other enactments applicable to the mentally retarded in North Carolina are also included. Some citations from the general statutes of the State, based on legislative enactments, are listed:

Chapter 35, Article 12, Sections 73-77 (from Sessions Laws 1963, Chapter 669).

The General Assembly passed a bill to create the North Carolina Council on Mental Retardation (Details are included under "State Organization.).

H. R. 1026 - A Joint Resolution creating a commission to study the public school system of North Carolina (item 10, above), July 1967.

The House of Representatives resolved, with the Senate concurring, to establish a Governor's Study Commission on the Public School System of North Carolina to the end that some evaulation of the effectiveness of the public school program might be achieved.

H. B. 874 (S. B. 403) - An act to make appropriations to the Department of Mental Health for grants-in-aid to provide a sheltered occupational environment for certain mentally retarded persons and to provide for day-care and residential care for certain mentally retarded persons, Session 1965 (item 6, above).

These were the original proposals for monthly grant-in-aid payments to the mentally retarded receiving services from sheltered workshops and day care facilities.

S. B. 240 (duplicate of H. B. 525), Session 1967 - An act to appropriate funds to the State Board of Health for the development and expansion programs for the mentally retarded (item 8, above).

This bill provided for a biennial allowance of $276,528 for the establishment of a Medical Genetics Counselling Center to provide statewide services, $250,000 for the expansion of existing Developmental Evaluation Clinics, and $189,000 for the purpose of establishing additional Child Health Supervisory Clinics in various counties throughout the State.

H. B. 524, Session 1967 - An act to appropriate funds to the State Board of Education for scholarships and training teachers of mentally retarded children (item 4, above).

A bienniel appropriation of $100,000 was given to the State Board of Education to be added to the fund for scholarships aid to all levels of college students who wish to train for placement as teachers of mentally retarded children.

S. B. 408, Session 1967 - An act to appropriate funds for the construction and operation of two pilot community complexes so as to provide day care, residential care, and other services to mentally retarded children and adults (item 3, above).

The State Department of Mental Health was given $150,040 to pay the 22% State share for the construction of the community complexes in Mecklenburg and Guilford Counties. An additional amount of $112,048 was allowed for costs of operation..

H. B. 1038, Session 1967 - An act to authorize counties to expend non-tax funds to assist state licensed facilities for the mentally retarded.

The Boards of County Commissioners were authorized to expend non-tax revenues to aid any private or public, licensed facility for the mentally retarded whether located within the borders of that county or not.

In May 1969, upon request of the North Carolina Bar Association's Committee on Mental Retardation and the North Carolina Association for Retarded Children, the Attorney General of North Carolina expressed the following formal opinion which might have future legislative implications. It was the Attorney General's conclusion that mentally retarded children are entitled to appropriate schools and teachers to develop their educational capacities insofar as possible, and it is the duty of the State to provide for such education. Mentally retarded children constitutionally are not to be discriminated against because of their mental retardation and mentally retarded children have the same constitutional right to the educational facilities of the State as that afforded to normal children who do not suffer from any disability.

In a talk to the NCARC, following the release of the opinion, the Attorney General suggested, that if necessary, this opinion should be tested in the courts of the State.

The 1968-1969 session of the General Assembly produced some new changes on programs for the mentally retarded. Some items of interest are listed.

> The Western Carolina Center in Morganton received $615,000 to develop an infant stimulation unit which would involve groups of families in a "mini-community" concept; i.e., group problem sharing or a sharing of a group of children and families assets through group participation on the part of families in detection and treatment.
>
> Upon recommendation that the trainable class grants-in-aid allowance be raised to $100 per month, the Advisory Budget Commission recommended an increase to $75 per month and increased overall funds to allow for 485 new pupils in trainable classes.
>
> H.B. 585, providing bus transportation for handicapped children, was enacted into law along with an appropriation for $735,857.
>
> The Department of Community Colleges received increases in appropriations to enable it to support programs in community colleges and technical institutes for the training of recreation aides, social work aides, day care help, cottage attendants, etc.
>
> A bill was approved which would provide for the continued medical care coverage of the mentally retarded child who reaches the age of 19 or above and remains as a family dependent and part of the family unit.

Among the bills that were not approved by the General Assembly or were shelved fo future consideration were the construction or support of group homes for the older retardate and grant-in-aid to residential facilities for the severely handicapped child under six.

Services

Residential Institutions

There are four State-supported mental retardation centers located throughout the State: (1) Murdoch Center in Butner, (2) O'Berry Center in Goldsboro, (3) Caswell Center in Kinston, and (4) Western Carolina Center in Morganton. The four State mental hospitals accommodate those retardates with emotional disturbances. The total residential population of the centers was 4,674 in 1968.

Private Residential Institutions

Private, non-profit, residential institutions are authorized to receive $120 per month per child through the Department of Mental Health. The private institution in North Carolina plays a role in statewide programs because of the policy of State institutions not to admit children under the age of six. Hilltop, Holy Angel, and Carobell have a combined, current capacity for 113 children.

Community Centers

Two pilot community mental retardation complexes were authorized by the 1967 General Assembly as a matching program for funds provided under P. L. 88-164. The Mecklenburg Center for Human Development, Charlotte, completed the first phase of construction in 1970. The Guilford County Mental Retardation Complex, Greensboro, is scheduled for completion in September 1971.

Day Care

Day care started in North Carolina in 1961 with ten facilities. There were 43 day care facilities in the State in December 1969 serving a total of 237 children. In the 1969 General Assembly an allowance of $40 per month per child in day care was authorized. The total legislative appropriation for per capita day care allowances, sheltered workshop, and residential facilities was $240,000 for fiscal year 1969.

Sheltered Workshops

Day care and training for the older group of mental retardates was being provided by 35 sheltered workshops. In 1965 there were fourteen sheltered workshops in the state. In July 1970 the total capacity of the workshops, including evaluation, training, work activities, and day care was 2,419. The actual number of individuals in workshop activities during that month was 1,513. Of these, 166 were in the process of being evaluated, 645 were in training, 234 were in work activities, and 77 in day care. For those in workshops being supported by the Division of Vocational Rehabilitation, subsidy payments ran between $88 to $121 per month per individual depending upon the status of the individual being subsidized. For those who fell in the category of day care, subsidy payments of $40 per month per individual were made to the workshops by the Department of Mental Health.

Rehabilitation

The Department of Mental Health and the Division of Vocational Rehabilitation, working cooperatively, have established five facility programs to assist the mentally retarded. These programs are located at the State Mental institutions: Caswell Center, Kinston; Dorethea Dix Hospital, Raleigh; John Umstead Hospital - Murdoch Center, Butner; Broughton Hospital - Western Carolina Center, Morganton; and Cherry Hospital - O'Berry Center, Goldsboro. Sheltered workshops are operated at O'Berry Center, Murdoch Center, Western Carolina Center, and John Umstead Hospital.

At the end of fiscal year 1968-69, Mental Health and Vocational Rehabilitation, by pooling their funds with those of local non-profit boards, had established six rehabilitation homes to serve the mentally handicapped - two in Durham, and one each in Greensboro, High Point, Charlotte, and Winston-Salem.

During the fiscal year a total of 4,402 individually were served by these programs.

The Division served 22,922 individuals during fiscal year 1969. Of these 3,165 were classified as mildly retarded, 983 moderately retarded, and 252 severely retarded.

In the fiscal year 1969, the total budget of the Division was $13.5 million of which $3.4 million were State funds and $10.1 million federal. The Division estimated that $6.6 million of the total budget were used for case services and the balance for general administration and support of specialized facilities.

Developmental Evaluation

The Board of Health administers the Developmental Evaluation Clinic program of the State. Program history is traceable to the first clinics for the developmentally handicapped established in 1959 in Charlotte, Morganton, Oxford, and Washington. The first actual Developmental Evaluation Clinic was established in 1961. At the present time there are a total of eleven Developmental Evaluation Clinics, plus a branch clinic in Edenton.

In 1959, 79 patients were served; in 1962, the number was 239; in 1966-67, the total was 2,206; in 1967-68, the total was 3,181; and in 1968-69, the total was 3,600. The Department of Health claims that North Carolina had better geographical coverage than any other state in 1968-69; admitted more patients than any other state; and served more children per 1,000 residents than any other state.

There are three variations in major function among the clinics. Training and research are emphasized at the three medical centers, where large numbers of professionals receive specific training with respect to developmental handicaps. The Division of Disorders of Development and Learning at University of North Carolina School of Medicine is funded directly from the Children's Bureau.

At East Carolina College and Western Carolina College the major emphasis is service to patients, but a considerable amount of training is provided for degree students at the master's level and some at the bachelor's level.

The other five clinics place the major emphasis on service, but do provide some in-service training for professional workers in surrounding communities.

Caseloads statistics of the eleven Developmental Evaluation Clinics show a total of 3,600 active cases carried in 1968-69. The number of active cases ran from a low of 62 cases for the Oxford facility to 846 for the Winston-Salem facility. New admissions for the year came to a total of 1,083 of which the fewest (21) were admitted in Oxford and the greatest number (229) by the Greenville DEC.

There are no local funds in the Developmental Evaluation Clinic program. Sixty-five percent of costs are financed by the Federal government (Children's Bureau) and 35% by the State. The University of North Carolina facility is funded separately. A total of approximately $700,000 were expended by the clinics during the previous year.

Newborn Metabolic Screening

The program for the screening of newborns is conducted by the Mental Retardation Section of the Department of Health. The State's voluntary PKU program began in 1966. The Department's statistics indicate that 94% to 95% of all newborns are screened yearly and that 16 cases have been detected since the inception of the program. The Department also started a tyrosinemia screening program in September 1969 as an adjunct to the PKU program and is now in the process of establishing a galactosemia screening program. For patients positively diagnosed, hospitalization and special formula costs are paid for by the Mental Retardation Section.

Genetics Counseling

The genetics counseling program, authorized by the legislature, is supported by the Department of Health. The State facility is to be located at the University of North Carolina, Chapel Hill. It is estimated that when in operation, the facility will provide state-wide services to all families.

Social Services

The programs of the Department of Social Services are primarily administered through the 100 county departments of social services. The State agency supervises programs of aid to families with dependent children and aid to the disabled. The counties administer these programs.

The state-wide caseload on the aid to disabled program is approximately 27,000. The caseload on aid to families with dependent children was 134,170 parents and children. The maximum monthly payment on aid to the disabled is $110 per month. The actual payment for June 1970 was $75.93.

The Departments of Mental Health and Social Services cannot collaborate on all problems of the mentally retarded because of some restrictive Board policies. For example, when an individual is given a $40 per month grant-in-aid payment by the Department of Mental Health, the Department of Social Services which is allowed to pay up to $75 per month for qualified individuals, cannot supplement the subsidy because of departmental policies.

Special Education

The 100 county and 52 city school systems in North Carolina are not independent, self-governing districts with local revenue authority. Authorizations for staffing and funding are forwarded by the State Legislature to local school units via the State Superintendent, the County Superintendent, and the County Boards of Education. The option of special education for the handicapped is exercised, because of this arrangement, by the State and not the local unit.

The action taken by the 1969 General Assembly to authorize non-categorical special education teacher allotments to local school administrative units has special significance in this context. The allotment or authority to hire a teacher was specified in this instance in accordance with a formula based on projected attendance and the number of teaching positions available in all the categories of handicapping conditions.

Education for the trainable mentally retarded lies outside of regular funding channels and is not included in this allotment authorization.

In this type of dependent system of education, this authority is considered a major step toward giving the local school units flexibility and authority to develop special education programs for the handicapped. It is still, to a great extent, a State controlled authority as illustrated by the administrative guidelines provided to local school units which state that within five days following the first month of school, any positions unfilled shall be released by the county or city board of education for possible reallocation by the State Board of Education.

The education program for the trainable mentally retarded in North Carolina is governed by a separate set of rules and regulations prepared by the Board of Education in accordance with the 1967 laws established by the Legislature. Funding, at the level of $75 per month per child or $675 per annum, is based on reimbursement determined by average daily attendance plus the average of absences caused by contagious diseases. Local boards of education cannot add additional classes after the approval of a plan without the submission and approval of a new budget and, in no instance, can the reimbursement to a board exceed the amount budgeted from State funds.

Teachers of the trainable mentally retarded are required to have two years of college education. In education programs for the mentally retarded, the State pays the base salary of teachers. Salaries are or can be supplemented with local funds.

The Council, in its report to the Department of Health, Education, and Welfare on P. L. 88-156, stated that only about half the children in North Carolina who could benefit from placement in special education are receiving that service. The Council went on to report that they intended to urge school boards to allot additional classes for the mentally retarded and encourage more students to train for teaching the mentally retarded. The Council, in 1968, was concerned with the effectiveness of testing and screening procedures to identify those children with learning difficulties and the State's school attendance law as it affected the retarded child.

In the 1969-70 school year there were 1,988 classes for the mentally retarded in North Carolina; approximately double the number of classes that existed in the State in 1965-66. An estimated 26,000 educable mentally retarded children and 2,750 trainable mentally retarded children were enrolled in those classes. Less than half of each of those enrollments existed during the 1965-66 school year.

In their request for Federal funds for the 1970-71 school year, the Division of Special Education estimated that a total of $44 million would be required for special education in North Carolina. Approximately $25 million of that amount would be non-federal funds. The estimated State appropriation was listed as over $24 million. Five hundred thousand dollars were expected from local sources. Of the total estimated expenditure of $44 million, $2.6 million were to be allotted to programs for the trainable mentally retarded and $14.4 for the educable mentally retarded.

The report listed actual enrollments for the 1969-70 school year as 25,486 educable mentally retarded and 2,300 trainable mentally retarded. The number of teachers allotted to the educable mentally retarded was 1,517; 212 teachers for the trainable mentally retarded were listed as being supported by the State's grant-in-aid program. The estimated number of children not being served was 16,514 educable mentally retarded and 1,300 trainable mentally retarded.

Corrections

The Board of Juvenile Correction estimates that 300 to 500 mildly retarded children and youth (out of a total population of 2,200) are committed to the Board's eight schools. Forty-six delinquent, aggressive, mildly retarded boys are placed in Cottage D of the C. A. Dillon School.

The Board is responsible for deliquent boys and girls up to the age of eighteen. Juvenile courts in North Carolina are responsible for commitments up to the age of 16; higher courts up to 18. Those children with I. Q.'s lower than 50 are referred to residential institutions for the mentally retarded.

The Cottage D program of the C. A. Dillon School consists of four main parts: (1) reduce aggression; (2) raise achievement levels; (3) develop personal social skills; and (4) recreation.

The operating budget for 1970 consisted of $487,000 in State funds. The school program is partially supported by the Department of Public Instruction. The cost for teaching and care of the children in the Dillon School is estimated at approximately $4,000 per child per year.

Recreation

In 1969 the North Carolina Council on Mental Retardation encouraged or sponsored fifty summer day and overnight camps for the retarded. These and other programs were listed in a directory of summer camping programs for the retarded. Other Council activities in recreation included a survey of all existing recreational services and facilities and the sponsorship of a workshop in 1968 to acquaint physical education teachers with techniques for programs for the mentally retarded.

Sources for Additional Information

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5. WASHINGTON

General Characteristics of the State

Area, Population, and Income

Washington, the most northwesterly state of the United States, is bordered on the east by Idaho and on the south by Oregon. Its land area of 66,663 square miles places it 20th in size among all states and third, after California and Colorado, among the five states being studied. Its 240-mile western boundary is the Pacific Ocean. Its 360-mile northern boundary is British Columbia.

In 1970 Washington had a population of 3,409,000 placing it 22nd in national rank. Its growth rate of approximately 20% in the 60's was 30% higher than the national average for that period. Washington ranked fourth in population, above Colorado, of the five states being studied.

Compared to Oregon and Idaho, Washington is the smallest in size but the most populated. Oregon covers a land area of 96,209 square miles (almost a third greater than Washington) and has a population of 2,091,000. Idaho, covering a land area of 82,677 square miles, had a 1970 population of 713,000.

A population density of 51 persons per square mile of land in 1967 placed Washington 31st nationally and fourth among the five states. Oregon, by comparison, had a population density of 21 and Idaho less than nine persons per square mile.

Colorado and Oregon are similar in terms of population and population density. Both have approximately 2,000,000 residents and a density of 19 to 21 persons per square mile. However, Washington is more like Colorado than Oregon in terms of population distribution. Where 70% of the population in Colorado are clustered in metropolitan areas (along the north-south axis bordering the eastern slope of the Rockies), approximately 65% of Washington's population reside in metropolitan areas. As in Colorado, Washington's population axis lies along a north-south corridor paralleling and extending south from Puget Sound. Unlike Colorado, however, the State of Washington has a population center in the Spokane area at the opposite, eastern end of the State.

The metropolitan population of Washington reside in four Standard Metropolitan Statistical Areas, three of which are located within the State and one mostly in Oregon. The largest of the four is the Seattle-Everett SMSA on the east shore of Puget Sound; the second largest surrounds Portland, Oregon, directly to the south; the third, Tacoma; and the fourth, Spokane on the eastern edge of the State. In 1968, the Seattle-Everett SMSA had a population of 1,300,000 (more than one-third of the entire State population). Spokane, the smallest SMSA, had a 1968 population of approximately 273,000.

The Seattle-Everett SMSA and the Tacoma SMSA lie in the Puget Sound region, one of the seven distinct geographic regions of the State. The other six are the Olympic Penninsula region, west and across the Sound from Seattle; the southwestern low coastal plains region; the dominant central Cascade range running north to the Canadian border and south to the Columbia River which marks the Washington-Oregon border; the Okanogan Highlands in the northeast corner of the State; the Columbia Plain which lies south of the Okanogan Highlands; and the Blue Mountains region in the southeast corner of the State. Spokane, the eastern most populated area of the State, lies in the Columbia Plains region.

Washington, like Colorado, is traversed by severe mountainous terrain in the central section of the State. Access between east and est is constrained by the terrain barrier. The central Cascades, in addition to being the distinctive topographic barrier, marks the boundary between the mild coastal and the harsh plains climates.

Among the five states being studied, Washington ranks second behind California in per capita personal income, general revenues received by the State, and general expenditures made by the State. Revenue per capita vs. expenditure per capita runs in favor of the State in ranking but toward the consumer in actual dollars. The per capita revenue of $563 per annum placed Washington in eighth place while the higher per capita expenditure of $565 placed the State in tenth place nationally.

Washington's per capita personal income of $3,521 per annum in 1967 compared favorably with the national average of $3,159 per annum at that time. Among the five states, California, Washington, and Ohio exceeded the national norm while Colorado fell slightly below and North Carolina far below average.

In 1967 the gross of all personal income in the State of Washington amounted to $10,900,000. In terms of gross personal income Washington ranked 20th nationally. In terms of per capita income the ranking of Washington rose significantly to 11th place.

Local Governments and Districts

Washington has 1,652 local governments with some or complete authority to levy taxes and incur debt. Of these thirty-nine (39) are counties, 267 municipalities, 346 school districts and 63 townships. All of the 63 townships are located in two counties - Whatcom County on the Canadian border and Spokane County on the eastern Columbia Plain. These townships, which serve inhabitants of areas that are defined without regard to population concentration, have authority limited mostly to roads, cemeteries, and the like. The principal subdivisions of Washington are essentially the 39 counties and the 267 municipalities lying within those counties.

Counties in Washington tend to group into five areas: (1) the Pugent Sound region embracing the twelve counties bordering on the Sound dominated by King County; the population center of that region and the State; (2) the southwestern region consisting of seven counties with the population center in Clark County, the northern arm of the Portland Standard Metropolitan Statistical Area; (3) the eight counties in the Central Cascades region with the centroid of population in the Yakima Valley area; (4) the northeastern region and its five counties extending south to Spokane; and (5) the modestly populated southeastern region at the Oregon, Idaho, Washington tri-state junction consisting of seven counties.

In 1967 King County was the only Class "AA" (500,000 or more inhabitants) county in the state. Of the sparsely populated counties, four fell into the classifications of 8th or 9th class (under 5,000 inhabitants) counties: Ferry County in the northeast region, Garfield in the southeast region, San Juan consisting of the cluster of islands in the Sound, and Wahkiakum, one of the smallest counties, lying near the Pacific outlet of the Columbia River in the southwest corner of the State.

The 346 school districts operated 1,589 public schools in 1967 for an average number of schools per district slightly higher than the national average. The number of enrollees in public schools was approximately 800,000.

Public school districting in Washington is following the national trend of reducing the number of districts in a state. Ten years ago there were 471 school districts in Washington. In all 51 states only eight have increased the number of school districts in recent years, and of these, only three have made increases of any significance.

In the State of Washington, as in 24 other states, the school districts are independent units authorized to levy school taxes and issue bonds with the consent of the local voting resident. Each county is also designated a "county school district" which, unlike the local school district, is an arm of the county government. County districts are supervised by an elected county school superintendent and five members of the county board of education. Local school districts are governed by five or three, depending upon the size of the school district, elected district directors. The State educational system is directed by an elected State superintendent of public instruction.

King County with the largest proportion of the State's population, has 21 school districts, the largest number of school districts for any one county in the State. Metropolitan Denver, Colorado, by comparison, has one school district. Three counties have nineteen school districts: Pierce County at the southern end of Puget Sound, the second most populated county in the State; Whitman County, south of Spokane; and Stevens County, in the northeast region, with a sparse population dispersed over a large land area.

At the lower end of the ranking,Garfield and Wahkiakum Counties have one school district for the entire county. San Juan County, consisting of a cluster of islands in the northern Sound with a smaller land area and a sparser population than Wahkiakum County, has five school districts compared to the one for Wahkiakum.

The greatest number of school systems (122 out of 346) operate only one school. Only twelve of the school systems operate more than twenty schools. Of the 122 school systems operating one school, only one is co-terminus with county territory and five are co-terminus with city boundaries. The majority (340) cross over local government boundaries.

Revenue and Expenditures

Total general revenues for the State amounted to $2.3 billion in 1967 placing Washington 13th in revenue rank in the United States. Half of this amount came from tax revenues. Gross expenditures for the same year ran slightly higher than revenue.

Tax revenue amounted to $1.1 billion. Taxes on sales and gross receipts accounted for 60% of this income. Washington, like Ohio, collected no revenue from taxes on individual income. Local governments in Ohio, however, do collect revenue on personal income. In Washington, neither the State nor the local governments collected revenue on personal income.

Of the $2.3 billion in direct expenditures, Washington spent $508 million on local schools in 1967. Over 99% of these funds were disbursed through local school systems. Public welfare funds, amounting to $135 million, were handled mostly by county agencies with a small amount being disbursed through the townships in Whatcom and Spokane Counties. Fifteen million dollars in health funds were evenly disbursed through counties and municipal agencies.

During that year funds appropriated to local governments by the State, in certain categories, were as follows:

Education of handicapped children (Department of Education funds to local school districts)	$11,830,000
Vocational education federal funds distributed in fixed ratio to local expenditures	7,100,000
Public welfare funds for medical and hospital services	6,800,000
Local health services	1,700,000

State Organization

The State of Washington, like California, has consolidated the activities of all health and social affairs departments into a Department of Social and Health Services. The new department will absorb the former departments of institutions, health, public assistance, and vocational rehabilitation. References to the various departments providing services to the mentally retarded in Washington follow the old organizational format.

There are five primary units of organization of the State government directly concerned with the problems of the mentally retarded: Department of Institutions, Department of Health, Department of Public Assistance, the Superintendent of Public Instruction, and the Division of Vocational Rehabilitation.

Mental retardation programs in the Department of Institutions (Dr. William Conte, Director) fall under the jurisdiction of the Office of Developmental Disabilities

Samuel Ornstein, Supervisor). The Division's programs include the blind and the deaf with major emphasis on mental retardation. The Director of the Department of Institutions is appointed by the Governor with the advice and consent of the Senate.

The authority of the Director of the Department of Institutions includes jurisdiction over the state hospitals, the state penitentiary, the state reformatory, the state school for girls, the state soldier's home, the Washington veterans' home, the state narcotic farm colony, and the school for the custody and care of children and youth. Authority over the institutions for the mentally retarded and the state schools for the blind and the deaf are vested in the Office of Developmental Disabilities. The state schools for the mentally retarded are the Fircrest School, one of the few residential facilities located in a metropolitan area, Interlake School, Lakeland Village, Rainier School, and the Yakima Valley School.

Programs for exceptional children under the Superintendent for Public Instruction (Louis Bruno, State Superintendent) are located in the Division of Curriculum and Instruction (Dr. Chester Babcock, Assistant Superintendent), one of the four divisions in the department. Programs for special education in the Curriculum and Instruction Division are directed by Dr. John Mattson.

The Department of Health (Wallace Lane, M.D., Director) is organized into three major services groups: Health Services, Community Organization and Services, and Environmental Control. A fourth organizational unit, the Office of the Assistant Director for Planning and Evaluation (Dr. Thomas Anderson, Assistant Director), is responsible for the coordination of planning efforts of the Department of Health and local health departments.

Crippled children's services and the maternal and child health programs fall under the jurisdiction of the Health Services Division of the Health Services group (Jess Spielholz, M. D., Deputy Director). Children eligible for care under the crippled children's program include those affected by phenylketonuria and similar metabolic disorders, and birth injury and other disabling or disfiguring deformities. The maternal and child health program also falls under the jurisdiction of the Health Services Division. This program promotes the establishment of prenatal and well-baby clinics and otherwise provides maternity, infant, and child health services.

The health facilities licensing program and the health facilities planning and construction program fall under the Division of Health Facilities also in the Health Services group. Hill-Burton funds are administered by this division.

The migrant health program is located in the Division of Local Health Services of the Community Organization and Services group.

The Department of Public Assistance (Sidney Smith, Director) is divided into four divisions. The Division of Medical Care and the Division of Social Services are the two units most concerned with the mentally retarded. The Department's activities are administered through five district offices located in Ephrata, Spokane, Seattle, and Olympia. Twenty-two field offices are disbursed throughout the State.

Programs of interest in the Department of Public Assistance are aid to families with dependent children, child welfare services, disability assistance, medical assistance for non-recipients of public assistance, licensing of child care agencies, and the development of personal care (board and room with personal care) facilities.

The Division of Vocational Rehabilitation (R. M. Ryan, Director) is the fifth organizational unit in the State government of Washington concerned with problems of the mentally retarded. The Divisions of Vocational Education and Vocational Rehabilitation report to the Coordinating Council for Occupational Education. The Division's programs include vocational agriculture education, home and family life education, trade, industrial, and technical education, and vocational guidance and counseling.

Planning and Planning Coordination

Washington's comprehensive plan for the mentally retarded, "Everybody's Children" was developed by an appointed 20-man Governor's Mental Health and Mental Retardation Planning Committee. More than one hundred recommendations were developed through a series of ten regional conferences and reports from 39 counties. Recommendations were developed in the areas of coordination and administration, diagnosis, prevention, home training, and the like. The plan stated that out of a total population of more than 3 million persons, approximatly 95 thousand were estimated to be retarded. The recommendations for services to be developed reflected the concerns of the various groups that participated in the preparation of the plan.

Subsequent to the publication of "Everybody's Children," a Governor's Advisory Council on Mental Health and Mental Retardation was established and Community (County) Mental Retardation Boards were authorized by the Legislature. Both groups were given the authority to plan for mental retardation services or to review such plans. Planning functions also exist in the State Departments of Institutions, Health, and Vocational Rehabilitation. Comprehensive Health Planning, reporting to the Planning and Community Affairs Agency, and the Department of Commerce and Economic Development do not play a direct role in planning mental retardation services; however, their recommendations have an effect on statewide programs.

The Governor's Advisory Council was established in 1965 to comply with the state planning requirements of the Mental Retardation Facilities Construction Act of 1963 (Public Law 88-164). The Council, consisting of eleven members including the Director of the Department of Health, the Director of the Department of Institutions, the Director of the Department of Public Assistance, the Superintendent of Public Instruction, and seven non-government representatives, was empowered to advise and consult with the governor on programs for mental health and mental retardation. The scope of the Council included construction programs for mental retardation facilities and community mental health centers, the development of rules, regulations, and standards for the operation of such facilities, and the development and review of plans for mental health and mental retardation. No staffing authorizations were provided. The budget for the Council, although not so specified in the enactments, was included in the accounts of the Department of Institutions. Some staff services were later provided by the Office of Comprehensive Health Planning.

The Revised Code of Washington states that each department or agency administering federal or state funds which provide services to the mentally retarded shall consult with the Advisory Council. Among the duties specified is the development and preparation of state plans which may be necessary to establish the eligibility of the state or any community to participate in any program established by the federal government relating to mentally retarded persons. Departmental duties also include reviewing and approving the plans of community mental retardation organizations which require the expenditure of state or federal funds.

By legislative enactment, the State of Washington authorizes county commissioners to appoint a community board to coordinate all of the local mental retardation services. The Revised Code of Washington states that the board shall consist of not less than nine nor more than fifteen members appointed by the Board of County Commissioners. These appointees, serving without compensation, shall include, but not be limited to, representatives of public, private, or voluntary organizations, and local governmental units which participate in a program for the mentally retarded and private citizens knowledgeable or interested in services to the mentally retarded. In order to be eligible for State funds, an agency of the State government may require the county boards to make comprehensive plans for present and future development of services to the mentally retarded. County boards may receive funds, expend monies, and collect a tax of one-tenth of a mill on the assessed valuation of the taxable property in the county. The County Board of Commissioners are required to budget and levy this tax for the coordination of community mental retardation or mental health services. The millage levy was enacted by a House bill in 1967.

Multi-county planning regions such as exist in California, North Carolina, and Ohio were not established in Washington. However, the Department of Commerce and Economic Development divided the state into thirteen planning regions in August 1969. The Department recommended that these regions be used for all planning purposes in the state. Comprehensive Health Planning uses the areawide health planning recommendations of community health agencies in Washington, D. C.

In the State of Washington, the term "catchment area" appears in planning documentation. "Catchment area" is the designation for a sub-county territory. This concept appeared in 1967 when legislative authority was given to County Boards of Commissioners to organize and deliver mental retardation and mental health services.

The Department of Institutions issued a "Planning Prospectus" in August 1968 and has since followed the original publication with a second volume. The Prospectus is an assemblage of ideas, concepts, and program possibilities from which the Department hopes that the professional staff, the decision makers, and the public will consider and accept certain proposals which they feel would be beneficial to the people of Washington. It is not a rigorous staffing and budgeting plan for new programs.

Among the items suggested by the Division for Handicapped Children is a program of "regional centers for the mentally retarded." Regional centers, in this context, refer to instituional services and not regional diagnostic services as the term is used in California and North Carolina.

The Division's suggestion for small residential facilities strategically placed throughout the State is based on the physical and functional isolation of the existing residential institutions from the community, the excessive size of these institutions, overcrowding in the Rainier School, and the ability of institutions to respond only with permanent or long-term care away from the family. Of the five states being studied, this is the closest that any state has come to proposing a more viable relationship between the institution and the community based on a network of institutions placed throughout the state.

Legislation

In the State of Washington legislative bills may originate in the House (H. B.) or Senate (S. B.). All bills, upon introduction, are assigned a House or Senate bill number. If signed and approved, the bill is assigned a bill chapter number in session laws. The authority of the bill is extended to agencies and departments via the appropriate section(s) of the Revised Code of Washington. Appropriations bills in the House are handled in the same manner as any other bill. Appropriations bills in the Senate are handled not as regular bills but in the Committee of the Whole.

Legislative references to programs for the mentally retarded in Washington, therefore, can be and usually are cited in a variety of ways. The first community based incentive programs to help the handicapped are popularly referred to as "Epton" programs. Depending upon the source of the citation, they may also be referred to as H. B. 326, Chapter 251 session laws of 1961, or 72.33 RCW.

Selected House Bills, Chapters, or Codes governing programs for the mentally retarded in the State of Washington are listed below:

RCW 72.01.010 et seq. - Department of Institutions

This section establishes the authority of the Department of Institutions in the field of mental health and mental retardation. The advisory commission for the department is specified in section 72.01.330. The use of physical facilities by school districts and institutions of higher learning is authorized in section 72.01.450.

RCW 72.33.010 et seq. - State Residential Schools

This section provides for a comprehensive program of education, guidance, care, treatment, and rehabilitation of all persons admitted to Lakeland Village, located at Medical Lake, Spokane County; Rainier

School, located at Buckley, Pierce County; Yakima Valley School, located at Selah, Yakima County; Fircrest School, located at Seattle, King County; and such other like schools as may be established. Section 72.33.050 specifies that an educational program shall be maintained at each school and that the Department of Public Instruction shall assist the school in all feasible ways including financial aid. Section 72.33.070 specifies that the Department of Health shall determine the maximum number of children to reside in the residential quarters of the school. Section 72.33.080 specifies that the Department of Public Assistance shall aid the superintendents of state schools in the placement of residents into suitable foster homes. The "Epton" programs and the "Group Home Bill" are also included under RCW 72.33; however, they are listed separately.

RCW 71.16.010 - Mental Retardation and Community Mental Health

The authority to participate in federal programs under Public Law 88-164 is established under this section. It also authorizes the appointment of a mental health and mental retardation advisory council to the governor.

RCW 71-20-010 et seq. - State and Local Services for Mentally Retarded Persons (H.B. 303 and 304, 1967)

The policies of the state on the delivery of services to mentally retarded persons are declared. The code states the intention of the legislature to establish a central point of referral in the community for the mentally retarded and their families and the establishment of ongoing points of contact with the mentally retarded and their families so that they may have a place of entry for services and return as the need may arise. Section 71.20.040 authorizes county commissioners to establish community boards. Section 71.20.090 authorizes community boards to receive and spend funds. Section 71.20.110 directs county commissioners to levy a tax of one-tenth of a mil on the assessed valuation of the taxable property in the county.

Chapter 251 (H.B. 326) laws of 1961 - "Epton" Program for Day Training Centers and Group Training Homes

This was Washington's first program that provided funds to the Department of Institutions to help develop community based programs for the mentally retarded and physically handicapped. As specified in 72.33 RCW, the Director of the Department of Institutions is authorized to enter into agreements with any person, corporation, or association operating a day training center or group training home for the payment of maintenance, support, and training of mentally or physically deficient persons accepted for admission to a state residential school.

Chapter 166 (H.B. 465) laws of 1969 - The "Group Home Bill"

The "Group Home Bill" is also cited in 72.33 RCW. This bill authorizes the Director of the Department of Institutions to place residents from institutions into group homes and pay for their continued care and support. An appropriation of $405,000 was authorized for the biennium starting July 1, 1969. Chapter 275-36 of that same session established the rules and regulations under which the group homes would be implemented.

RCW 71.28.010 - Interstate Contracts for Mental Health and Retardation Services

This section authorizes any county or city within a county which is situated on the state boundaries to contract for mental health or retardation services with a county situated in Oregon or Idaho.

RCW 70.10.010 through 050 - Comprehensive Community Health Centers

This section states the policy of the State of Washington to provide, wherever feasible, community health, mental health, and mental retardation services within single facilities to provide maximum utilization of funds and personnel and to assure the greatest possible coordination of services. Agencies are authorized to apply for and administer federal funds for the construction and development of comprehensive community health centers in cooperation with counties, cities and municipalities.

RCW 70.83.010 - Phenylketonuria and Other Preventable Heritable Disorders

This section authorizes the Department of Health to promote screening tests of all newborn infants when such tests are available, practical, and indicated by sound medical practice. The Department, within the availability of funds, is also authorized to assist physicians or parents in cases of positive screening results.

Services

In the State of Washington there were two programs that were particularly interesting. One was in the field of education; the other in the Department of Institutions.

The responsibility of the Department of Education in Washington extends into the residential schools of the Department of Institutions. The significance of this program lies in the fact that classroom standards in institutions are the same as the standards for non-institutional classrooms. The Department of Education supports the institutional teaching programs financially and the teachers, who are certified by the Department of Education, receive pay commensurate with the pay of community teachers.

The second program has to do with the role of the institution in community affairs. Field workers are employed by the state institutions to work with individuals in the community. The workers are housed on the grounds of the institutions or in the community and can function as caseworkers or community coordinators. Usually, field workers or community coordinators are employed by and report to the responsible State or county office, not to the institution. This arrangement for staff utilization is unusual. In effect, the program ties the institution closer to the community and tends to reduce the separation between the two.

Residential Schools

The Division for Handicapped Children of the Department of Institutions is responsible for five residential schools: (1) Lakeland Village School at Medical Lake in eastern Washington, southwest of Spokane; (2) Rainier School in Buckley, inland from the southern end of Puget Sound; (3) Yakima Valley School in Selah in south central Washington; (4) Fircrest School in metropolitan Seattle; and (5) Interlake School also in Medical Lake.

The average daily population in July 1970 for all five schools was 3,694; lower by 288 than it was in July 1969. During the period between June 1969 and July 1970 the average daily population ranged from a high of 4,114 in October to a low of 3,882 at the beginning of the fiscal year. From the month of October on through the beginning of the current fiscal year there was a steady decline in residential population ranging between 20 and 50 residents per month with the exception of one month when there was a nominal decline of eight in total population.

School population ranged from a high of 1,433 in the Rainier School to a low of 197 at the Yakima Valley School. The other three schools had populations of 779 (Fircrest, Seattle), 278 (Interlake, Medical Lake) and 1,007 (Lakeland Village School, Medical Lake).

Total expenditures of all five schools for fiscal year 1970 was $22.5 million. Daily per capita costs ranged from a low of $12.87 at the Rainier School to a high of

$23.52 at the Yakima Valley School. The average daily per capita costs for all schools was $15.28.

The generally lower rate of admissions to the schools during 1970 is attributed by the Division to revised admissions policies and increases in the numbers of retarded individuals being serviced by day care centers in communities around the State.

In fiscal year 1970 a policy of regionalization was instituted whereby schools were assigned responsibility for service to individuals in specified areas. Interlake School continued to serve those profoundly and severely retarded children and adults needing intensive nursing care. The other four schools were given territorial assignments for that area of the State in which their schools were located.

The regionalization of the State schools is part of the Division's overall concept of providing successive levels of care for the mentally retarded in the State. The Division would like to establish a series of regional centers for residential care throughout the State and has proposed such a network for a number of years. The proposal has not been processed or approved.

The State of Washington claims to be one of the very few states without a parent pay bill; i.e., no financial levy imposed upon the parent for the institutionalization of a dependent. This allowance extends to adjunctive services as well as board and room.

Community Centers

In 1961 a bill was enacted which provided funding to communities to establish local programs for the mentally retarded. The Mental Retardation Grant-in-Aid Program is popularly known in the State as the "Epton" program.

The initial 1961 appropriation was $30,000 for the biennium. The latest biennial appropriation was $570,000 for the period 1969-1971. Part of this amount was to be allocated to counties for local mental retardation planning purposes. Another part was to be used for contractual purchase of residential care from privately owned and operated group homes. In this case, the resident is expected to share in the cost of care to the extent that his resources will permit.

Approximately 1,159 children and adults were served by 48 centers located in 23 counties. Thirteen of these centers are located in King County, five each in Snohomish and Spokane Counties, three in Pierce County, two each in Skagit, Whatcom, and Kitsap Counties, and a scattering of one each in various other counties.

The distribution of these centers throughout the State has been the subject of discussion. Discussions have centered around the lack of funding for Epton Centers, uneven distribution, the barriers to the poor, the lack of quality control in the centers, and staffing problems. These same problems have been reported in the community programs of all of the other states being studied. The polarization of opinion on how to cope with these problems is not unique to the State of Washington.

Presumably the allocation of State funds to local county boards would stimulate the counties without community programs to investigate the need for these services. In the State of Washington, although the county boards are legally empowered to levy property taxes for revenue, amounts collected have been inadequate to support programs. Supplementary appropriations of $120.000 have been made for county programs.

In all five states there is a tendency to blame the lack of service on the lack of funds. However, scattered groups have noticed that even for those funds available, there has been some inequity in services provided to middle income versus poor families and metropolitan versus rural areas. It is the contention of these groups that the primary problem of delivering equitable services to the mentally retarded might not be funding alone and that additional funding might not solve the problem of providing services to the poor or rural communities.

Group Homes

On July 1, 1969, a group home program was started in Washington with an initial biennial appropriation of $405,000. The object of the program was to establish group homes for children and adults residing in State schools but capable of functioning in community living situations. After one year, nine homes were in operation with a total residency of 135 individuals. Of the nine homes, five were adult homes; three for children, and one was for young adults. Of the 135 population, 78 were adults, 37 children, and 20 were classified as young adults.

Group homes for the adults are licensed by the State Health Department. Group homes for children are licensed by the State Department of Public Assistance. Each department has its own regulations requiring compliance. In general, however, both adhere to the definition that a group home is a residential facility capable of serving, among others, a maximum of 20 mentally and/or physically handicapped persons who are able to participate in community based programs. A formal agreement between the Department of Institutions and the Department of Public Assistance specifies that the Department of Institutions will organize and supervise the homes and that the Department of Public Assistance will generally accept the residents of these homes for support by that Department. State payments for support have been $200 per month per individual with an added allowance of $20 per month for expenses.

Special Education

In the school year 1968-69 a total number of 8,572 educable mentally retarded and 1,289 trainable mentally retarded children were reported to be enrolled in fourteen intermediate school districts. For the same period a total of 18,876 handicapped children of all types were reported to be enrolled in the school system. These figures are based on full-time equivalent estimates of attendence.

One hundred thirty-one school districts were reporting services to the mentally retarded under the State's system of permissive education for the mentally retarded.

In 1968-69 there were an estimated grand total of 328 school districts of which five were classified as non-operating third class districts.

As of the first day of October 1969, the grand total enrollment for all children enrolled in kindergarten through the twelfth grade was 820,482.

The Department of Education reported that 85% of the EMR and 65% of the TMR needs for education were being met in the fourteen intermediate school districts reporting services for the mentally retarded. This figure does not take into account the non-serving school districts. Estimates by different groups on the actual needs for special education vary considerably.

According to special education personnel in the State office, specific data on special education is inadequate and a registry is required before the actual needs of the mentally retarded in the State can be assessed accurately. Data systems have been proposed but there are no active plans to collect this information.

Total expenditures per pupil for all elementary and secondary grades have been estimated at $662.33 per annum. Special education supplements of $371 per pupil are made for mentally retarded individuals.

Transportation expenditures for all students came to a total of $25.4 million in 1968-69; approximately 5% of the grand total school expenditure of $576.9 million.

Vocational Rehabilitation

Services of the Division of Vocational Rehabilitation are provided to individuals who are vocationally handicapped by physical disability, mental illness or retardation, personality or behavioral disorders, alcoholism, lack of social competency or mobility, or by other factors required for gainful employment or self-care.

For the biennium 1969-71, $23 million were appropriated to the Division. This amount was significantly larger than the $13.7 million appropriated during the previous biennium. How much of the $23 million will be expended on the mentally retarded in the "Epton" day training centers or in other programs is not known.

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